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MULTIPLE TRANSFUSIONS

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THE end of the war and the caution in most lines of endeavor that attends it is again beginning to manifest itself in many clinical fields. This caution, coupled with the tendency of physicians and surgeons, both military and civilian, to pause and take stock of the vast number of reports, lectures and papers compiled during the war has been anticipated. Two months after the shooting has stopped have already passed and the war is beginning to become extremely remote in the minds of the civilian doctors who so capably took up the tremendous burden created by a military personnel demand. It is equally remote in the minds of many military surgeons. The race to return to "normal" as the present generation has learned to accept it will unquestionably slow the progress of gains already made, and the more critical evaluation of some procedures will necessarily ferret out the exceptions that prove the rule.

The development of multiple transfusions as a safe clinical procedure for the family doctor has been one of the outstanding contributions since the onset of the war, and already bids fair to find a position close to the top of the list. Many reasons will be pointed out to prove that the use of large quantities of blood by transfusion is unsafe. For a better evaluation of these forthcoming discussions, I wish to present the results of over 60,000 cc. of blood, plasma, or cells to a group of thirteen patients. The average number of transfusions was 10.4 per patient. As can be seen in the accompanying table, all blood types were represented. The least number of transfusions to any one patient in this group was three, and the greatest number thirty-three. Of the entire group, only two received less than seven transfusions.

A discussion of the various diseases and injuries requiring treatment by transfusion does not come within the scope of this report. The amount of blood given and the decision to transfuse was made in each case early after admission to the hospital. The type of transfusion first given in most cases was whole blood. That this is the transfusion of choice is adequately demonstrated in that 49,000 cc. of the entire amount fell into this group. A careful evaluation of the blood pressure, pulse and general appearance of the patient still remains the best immediate indication. Laboratory reports of a hemoglobin of below 7.5 grams, a red cell count of below 2,500,000, or an hematocrit below 25 were accepted as the indications for multiple transfusions, regardless of the admission diagnosis. Any one of the three tests will suffice but it has been my good fortune to have all three at very short notice.

In the establishing of a program to give safely numerous transfusions to one individual, all of the pitfalls were carefully considered. The many disagreements found in the literature concerning the pros and cons of blood transfusion for any particular diagnosis were also carefully evaluated. The net result was to prove that the same procedure was effective in every condition where acute or chronic blood loss had occurred. The patient with an active, uncontrolled, gastro-intestinal hemorrhage was treated the same as a patient with epistaxis or severe bleeding following a compound fracture. Volumes have been written about the bleeding gastric ulcer, and there is still no agreement as to what procedure is proper. Extreme differences of opinion have served to create confusion, rather than correct this particular problem in physiology. I have treated these patients by multiple transfusions in volumes sufficient to replace their lost blood as fast as they could absorb it. Reversal or correction of shock prepares them for surgery, but the case that will not respond to conservative therapy is the well known exception and usually dies on the operating table.

In this group of patients no less than 500 cc. of

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whole blood was considered as an adequate transfusion at any one time. Repeated transfusions of small amounts of blood, in my opinion has little to recommend it. The danger of blowing out the clot has been the main argument for the small and frequent amount. The classic theory of blood coagulation so universally accepted is in serious conflict with this postulation.

Donors with the same type blood as the patient were chosen in all cases. "Universal donor" blood was not used except to the type O patient. The "Universal Donor" still remains a cause of many undesirable immediate and remote complications, in spite of recent reports concerning the preparation of safe universal blood. In many instances "banked blood" was used, but no transfusion of blood more than 72 hours old was given. All of the blood, plasma and cells had been citrated, and the largest amount of whole blood given in 24 hours was 5000 cc. In this particular patient, two different donor bloods were given at the same time with no ill effects. There were several other instances in which three or more transfusions were given within the first few hours after admission with no reactions.

The preparation of the cell suspension was completed as has been recommended by other writers, the same care being taken to use cells which had been withdrawn not more than 72 hours previously. Although 4100 cc. of cells represents a relatively small amount to include in any report, the obvious benefits observed in those few patients makes it of value to mention.

In the preparation and cross matching tests performed on each patient, particular care was given to cross match only bloods of the same type. Both warm and cold agglutinins were tested for in each patient and considered carefully before the second transfusion was started. By these latter procedures, several incompatibilities were discovered in bloods that otherwise appeared compatible in cross matching at room temperature, and the donors promptly eliminated. The time consumed in taking this extra precaution is comparatively negligible. Among the major causes of intra-group reaction now known is the Rh factor, and although the percentage of positive cross matching tests is admitted to be small, any effort to prevent a reaction makes it worth while.

The necessary time to complete these tests would rarely exceed the time consumed in completing the first transfusion. Although no female patients are included in this report, the association between severe transfusion reactions and pregnancy makes careful testing even more important. The literature during the past year has presented several case reports wherein anti Rh substance has survived for

many years following the last pregnancy. In my own experience, I have observed a non-fatal hemolytic reaction in a 65 year old Rh negative female, transfused with blood from her Rh positive, 32 year old son. She was later transfused with Rh negative blood without reaction.

TRANSFUSIONS

Case No.	Type	Number	Blood	Volume (cc)	Cells	Reactions		Mortality
			Plasma	Number		Number	%	
1.	O	11	3500	250	1200	0		0
2.	O	3	1500	.....	.....	.....	.....	.....
3.	A	13	6500	.....	.....	.....	.....	.....
4.	A	7	2750	.....	500	.....	.....	.....
5.	B	9	2500	500	700	.....	.....	.....
6.	O	7	3250	.....	.....	2	28.5	.....
7.	O	5	2000	.....	500	5	100	.....
8.	O	33	5500	5600	.....	1	2.9	.....
9.	B	7	3500	.....	.....	.....	.....	.....
10.	A	10	4500	250	.....	.....	.....	.....
11.	O	10	5000	.....	.....	.....	.....	.....
12.	O	11	4500	500	1200	.....	.....	.....
13.	AB	8	4000	.....	.....	.....	.....	.....
Total		134	49,000	7100	4100	8	5.96	0

There were eight reactions of a mild nature in the entire group, or a percentage of 5.96. All types of reaction were recorded. This percentage was increased considerably by the fact that one patient had a mild reaction characterized by a temperature rise not exceeding 101 degrees, a chilly sensation, and generalized urticaria after each of 5 transfusions. The cause was not definitely determined, and repeated tests proved none of them to be hemolytic. The remaining reactions observed were likewise non-hemolytic. From the entire group it is reasonable to state that multiple transfusions of blood, plasma or cells will produce reactions in 1.5 to 2% more patients than the single transfusion. Although no hemolysis was demonstrated in any of the reactions, each was treated immediately by the injection of 5 grams of Sodium Lactate. Sodium Citrate in the same amount has been recommended as a means of immediate alkalinization of the urine, and in spite of its rapid oxidation in the blood stream has caused several untoward reactions in my hands, which were as disturbing to me as to the patient.

In any discussion of the end results of multiple transfusions, the physio-chemical changes always enter. The most conspicuous change in this field occurs in the blood urea nitrogen, but the elevation in no instance reached an alarming figure in this group of cases. The urea nitrogen determination in case number 8 reached a peak of 49 mgm./100 cc. on the fifth day after admission, but fell rapidly to normal at the end of ten days. This was the highest recorded in the entire group, which would seem to satisfy me that the blood urea elevations may be disregarded entirely if proper preliminary crossmatchings are made. Red cell fragility will not change materially in citrated blood that is used prior to the expiration of 72 hours. In each of these

patients a quantitative Van den Berg test was performed on the 7th day following the last transfusion, and in each case was reported as too low to read in the colorimeter. Red cell counts were maintained at a consistently high level with only minor reductions at the end of one week.

In conclusion, the consideration of multiple transfusions must call to mind the possibility that too much blood can be given. Over loading the circulation must never be overlooked, either with blood, plasma or cells. I might add that the patient in whom such a phenomenon appears is always the one for whom more blood or plasma appears indicated. Increased pulse rate, cyanosis, respiratory distress and cardiac arrhythmia are the important symptoms, and may end in death if venesection is not employed.

Summary

1. One hundred and thirty-four transfusions to thirteen patients are reported.
2. Reactions occurred in 5.96%.
3. The use of donor blood of the same type as the patient is stressed.
4. Repeated transfusions of the required amount of blood at short intervals is a safe precaution.
5. Whole blood remains the transfusion of choice where whole blood has been lost.

CASE REPORTS

Case Number 1.

Fifty year old male admitted to the hospital with a history of vomiting a large amount of blood on two occasions before admission. Red blood count before transfusion was 3,660,000. For the first six days after admission he vomited between a pint and a quart of blood each day. In spite of multiple transfusions daily his cell count dropped to 1,330,000 on his tenth hospital day. During this time he had been given 3500 cc. of blood. Bleeding stopped on his 10th day. During the second week he was given red cells alone for a total of 1200 cc., and an additional 1000 cc. of whole blood. His grand total of transfusions was 500 cc. of plasma, 4500 cc. of whole blood, and 1200 cc. of cells without reaction within 15 days of his original hemorrhage. X-ray studies at a later date failed to reveal any source of bleeding.

Case Number 2.

Twenty-five year old male admitted to the hospital, complaining that he was awakened at 5 A. M. by nausea, and promptly vomited a large amount of blood. This was repeated two times shortly after the original hemorrhage. His bowels moved at the time of his third vomiting spell, and consisted of a large black, watery stool. On admission his red blood count was 1,450,000, hemoglobin 4.5 grams

and hematocrit 14. He received a total of 6500 cc. of blood by transfusion in 500 cc. amounts and had no reaction until his 10th transfusion, which was given fifteen days after his initial attack of vomiting. We were unable to explain this reaction, but suspected it to be of pyrogenic origin. Tests for hemolysis were made and found negative. His Rh reaction was positive. He received three transfusions later without any ill effects or reaction. X-ray studies later revealed a healed duodenal ulcer. His blood chemistry, cell volume, hematocrit and hemoglobin remained at normal levels for the remainder of his hospital stay.

Case Number 3.

Forty-six year old veteran admitted to the hospital complaining of passing blood by rectum of two weeks duration. He had been having pain in his abdomen for nine months. He followed a diet for a while and then began to drink to treat a bad cold. He gave the history of fainting a few times during the two weeks prior to admission, and had lost thirty pounds in the preceding three months. Physical examination was essentially negative. His initial red blood cell count was 1,590,000, hemoglobin 4.25 grams, and hematocrit 16%. He was given a total of 2500 cc. of blood in 500 cc. amounts before his blood volume reached a normal figure. This was given over a period of three weeks. He was operated upon six weeks after admission, at which time the X-ray report of a lesser curvature ulcer was confirmed by subtotal gastrectomy. Post-operatively he was given 1000 cc. of blood and 500 cc. of plasma. At no time was there any evidence of reaction or cell destruction.

Case Number 4.

Thirty-seven year old male admitted with a history of right sided nasal hemorrhage occurring several times prior to admission. Red blood count on admission was 1,730,000, hemoglobin 6 grams, and hematocrit 18%. He was given 750 cc. of whole blood in 500 cc. amounts, and 500 cc. of cells during the first six days after admission without reaction. The bleeding was controlled by packing. He failed to show any sign of cell breakdown, and was discharged on his tenth day with a normal blood volume.

Case Number 5.

Twenty year old male admitted following a compound fractured femur sustained two days before admission while on duty at sea. His red blood cell count on admission was 1,350,000, hematocrit 12% and hemoglobin 4 grams. He was given a few plasma transfusions aboard ship, and during the first thirty-six hours after admission he was given 5000 cc. of whole blood. In this patient it is inter-

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MANIFESTATIONS OF DISEASES IN THE MOUTH*

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THE title of this evening's paper is sufficiently broad to allow an approach from a number of points of view. I propose, first, to consider the point of view of the physician examining the mouth of his patient, then, that of the dentist. Subsequently, I wish to discuss the merging of the two points of view; the physician and dentist discussing together the relation of disease in the mouth to the health of the patient. Finally, I should like to present the point of view of the research worker concerned with problems pertaining to diseases of the teeth and their attachment tissues.

The physician traditionally looks at the tongue of his patient during the physical examination. He notes the conditions of the teeth, if present, glances at the gums and palate and passes on to the throat and beyond the domain of the dentist. Someone has described modern medical diagnosis as diagnosis by exclusion. The well trained physician is familiar with the appearance of healthy soft tissues and is alert to notice deviations from the normal. He will look at the lips for the rhagades of congenital syphilis, the cheilosis of riboflavin deficiency or other signs of disease.

The tongue is remarkable for the number of indications it may give of the physical condition of the patient. Beside congenital malformations, which are rarely seen, there are muscular tremors and in-coordinations which may indicate central nervous system disturbances or thyroid gland hyperfunction. Then there are the common coatings of the tongue associated with fever or gastrointestinal disturbances. Microscopically these coatings are the result of retention of cornified cells on the tongue papillae. This promotes the multiplication of bacteria to enormous numbers which often cause a disagreeable odor.

Hypertrophy of the papillae may in rare instances give rise to the condition called black or hairy tongue. Black tongue in dogs has been asso-

ciated with Vincent's infection secondary to nicotinic acid deficiency, but the condition in man is apparently unrelated to this deficiency.

The fungiform papillae, when red and swollen, cause the "strawberry tongue" characteristic of scarlet fever.

A partial or complete atrophy of the papillae is found in the smooth tongue of pernicious anemia. Rather similar appearances may occur in pellagra. Localized and wandering patches of atrophy are found in geographic tongue. In swine, similar wandering lesions occur in pantothenic acid deficiency.

The palate may be the site of gumma or tuberculosis. Tumors of the palatal mucous glands, while not as common as tumors of the parotid gland, are not rare.

The gums are of interest in that metallic deposits there may be the first indication of lead or bismuth poisoning. Sulfides of these metals form in the connective tissue just below the free margin of the gingivae and show through the epithelium as a blackish stippling.

The gums and other oral mucous membranes may show early and distinctive signs of Addison's disease, scurvy, or Vincent's disease. Koplik's spots may be the earliest diagnostic sign of measles and the mucous patches of secondary syphilis may be first recognized in the mouth. Leucoplakia of the oral mucous membranes is looked for and if found, is viewed with suspicion as a possible site of malignant growth. Irritations from tobacco and from rough teeth or dental appliances assume an important place in the etiology of leucoplakia and of carcinoma. The latter may arise in irritated areas with or without the previous presence of leucoplakia.

The teeth themselves are, I believe, terra incognita to most physicians. The fact that Hutchinsonian teeth may indicate congenital syphilis is probably part of the background of knowledge retained from medical school days, but the more general principle that developmental defects of many types are accurately recorded in the structure of the teeth is less well known. Mottling of the teeth due to excess fluorine in the drinking water during the time the teeth are forming is a common clinical finding in some parts of the United States, but fortu-

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nately or unfortunately, it is rare in New England. Almost the only individuals in the city of Providence exhibiting fluorosis of the tooth enamel will be those born and spending the first few years of life in certain parts of Italy and Sicily. These patients, as is now well known, show almost complete immunity to dental caries, although their children born and raised in this country are often very susceptible to caries. This fact was once attributed to a change in the nutritional quality of the diet, but the incorporation of fluorine into the enamel appears at present to be more significant.

Tooth decay, unless advanced, is likely to escape the attention of the examining physician. Crowns, especially gold crowns and extensive bridges, arouse suspicion of the presence of foci of infection. Porcelain restorations, which may be quite as great a source of danger to the health of the patient, will probably not be detected.

Loosening of the teeth and pockets about the teeth from which, upon pressure, pus exudes will indicate a late stage of the common disease entity, pyorrhea alveolaris. The importance of this disease as a portal of entry of microorganisms into the blood stream is not as generally recognized as it should be.

Loosening of the teeth due to processes in the underlying bone such as Hans-Schüller-Christian disease, Paget's disease, cysts or tumors, is a possibility that should be kept in mind. The enlargement of the lower jaw and spacing of the teeth in adults is characteristic of acromegaly.

The list of signs of disease occurring in the oral cavity might be greatly lengthened. In general, however, it may be said that the physician is searching for deviations from the normal in the oral tissues which may serve as signs of systemic disease. Such signs are extremely rare among well people but are more numerous among the sick and, when found, may provide important leads toward the diagnosis of disease. Secondly, the physician is concerned with the teeth as foci of infection which may contribute to the ill health of his patient.

The dentist looks at the mouth of the patient primarily from the point of view of repair. This is essentially the point of view of the surgeon diagnosing and planning repair of a hernia, for example. It is in no sense derogatory. The dentist, like the otolaryngologist, is highly trained in the recognition of signs of disease and in the surgical treatment of that disease. The greater part of his practice is devoted to the treatment of tooth decay or its sequelae. His patients are not sick, generally speaking. No clear correlation has been made between good health and immunity to dental caries. Cleaning and polishing teeth to prevent the initiation of tooth decay has proven to be of limited effectiveness. Diet has been shown to be of great

significance during the formation of the teeth. In general, metabolic disturbances which adversely affect bone structure have similar deleterious effects on tooth structure which is being formed at the time. Tooth decay, however, attacks the most perfectly formed teeth almost, if not quite, as readily as hypoplastic teeth. There is ample evidence that diet is of great importance in building healthy bodies and maintaining resistance against infection. The evidence that diet is effective in controlling dental caries is somewhat less conclusive. The publications of Mellanby, Boyd, Howe, and their co-workers, indicate, however, that an adequate diet is of importance in lessening the incidence of tooth decay and of reducing its rate of progress. The influence of sweets on the promotion of dental caries has received much attention. Sugars and starches have been implicated both for prematurely satisfying the appetite by supplying calories without the proteins, minerals and vitamins necessary for a well balanced diet and for promoting the activity of acid production by bacteria on tooth surfaces, thereby dissolving the enamel and opening a pathway for the progress of tooth decay.

Nevertheless, the majority of dentists feel confident that early detection of tooth decay, complete eradication of the affected tooth structure and replacement by a filling is the only really effective method of dealing with dental caries. Even though the use of fluorine, the impregnation of enamel with nitrocellulose, or other non-surgical procedures should eventually prove successful in drastically reducing tooth decay, the dentist is all too well aware of the enormous amount of reparative work necessary at the present time. It is quite understandable then, that his attention should be primarily focused on the detection and the treatment of dental caries and of the replacement of teeth lost chiefly as the result of dental caries. Mechanical considerations are of great importance in dental restorations. Engineering is as important as surgery for the success of dental restorations. Without technical competence, good dentistry is impossible. Esthetic considerations are also important. Without modern dental care most of us would be sorry looking individuals. The functional efficiency of the teeth in mastication as a step in the process of digestion, is not to be disregarded.

All this makes it understandable that the dentist should focus directly on the teeth and the necessary repair work to be found there. This is by no means all of dentistry, however. The dentist is concerned with the growth and development of the dental arches and the relation of the teeth of one jaw to those of the other. Much of the responsibility for treatment of mal-development and mal-arrangement of the teeth has been delegated to orthodontics, one of the great subspecialties of dentistry.

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The growth of the face and the part the teeth play in that growth are a fascinating study. The influence of genetic and of environmental factors, including use, habits and diet, has received considerable study in an attempt to better understand the normal development of the dental arches and deviations from the normal. The use of mechanical forces in stimulating the growth of bone and thereby moving the teeth into normal alignment, has reached a high point of clinical application in a field which is, in essence, dental orthopedics.

Another major subdivision of dentistry is oral surgery. Surgical principles apply here as in any other field of surgery. The extraction of teeth is an important part of the work of the oral surgeon. It is surprising that in most instances a large gaping wound left by the removal of a tooth heals with only occasional complications. The use of the blood plasma products in such wounds appears to be a very promising means toward control of post-operative hemorrhage and toward promoting repair.

The extraction of teeth is by no means the entire field of oral surgery. The ends of root-treated teeth may be amputated, cysts and tumors removed, etc. The plastic surgeon is often concerned with the face and many outstanding plastic surgeons were primarily trained in dentistry. Most of these men have, in addition, medical training so that this is one region where medical and dental practice often merge.

There are a number of lesser fields in dentistry where specialization is developing, such as endodontia, periodontia and prosthodontia. Specialization in very narrow fields tends to develop knowledge and technique in these fields. The shortcomings of over-specialization are clearly recognized and there is a growing realization of the need for broad training for competent general practice, in dentistry as in medicine.

The problem of periodontal disease deserves special mention since it is, next to caries, the greatest cause of loss of teeth. The gingival attachment, like the nail bed or the hair follicle, is a point of low resistance to infection. Gingival inflammation leads to detachment of the soft tissues from the tooth, pocket formation, resorption of alveolar bone and, eventually, exfoliation of the tooth. Local factors such as calcareous deposits, impaction of food, faulty dental restorations and excessive occlusal forces are important in localizing periodontal disease. There has been recognized a systemic factor primarily affecting the bone and soft tissues of which we shall have more to say later.

The dentist tends to concentrate on local factors in the treatment of periodontal disease. He removes the calcified deposits, corrects the mechanical defects which allow impingement of food, relieves the

excessive occlusal forces and institutes massage and rigorous cleanliness on the part of the patient and in a fairly high percentage of cases the disease becomes arrested or clinically cured. The search for specific bacterial agents has not been successful. The influence of endocrine disturbances, dietary deficiencies, etc., has received considerable attention from some dental investigators and further progress along such lines is hoped for.

The lesions that were enumerated in the first section are infrequently encountered in routine dental practice. The dental practitioner has the advantage of seeing patients who are, generally speaking, in good health. He may be, however, the first to detect signs of diabetes, leukemia, carcinoma, etc., in the oral cavity. His record of referring the patient to the physician for further diagnosis and treatment is, on the whole, excellent.

This brings us to a consideration of cooperation between the physician and the dentist in their joint handling of a patient. One instance has just been mentioned, the case in which the dentist notices some unusual sign of disease, perhaps in the mouth of a patient whom he has cared for over a period of years. The reverse is when a physician detects evidence of dental disease and refers a patient to the dentist for its treatment. In such cases, the physician has in all too many instances, assumed superior knowledge and has not hesitated to order the removal of teeth which he regards as infected. Comroe, Collins and Crane,¹ in a book which was written for dentists, but by which many physicians might profit, write as follows on this point:—

"The authors feel very strongly that still closer cooperation and understanding must exist between internist and dentist. The dentist must be regarded by the internist as a consultant in the same sense as is the otolaryngologist, the roentgenologist, or the dermatologist. The physician must not tell the dentist what should be done in the mouth, but should carefully consider the dentist's report concerning his patient. The dentist should not merely have the patient return to the internist, with the x-ray films of his mouth, as many medical men have practically no training in the interpretation of such films. The complete report from a qualified dentist is extremely useful to the physician."

"Dental focal infection usually implies periodontitis (pyorrhea alveolaris) or periapical infection. Unfortunately, most medical men know very little concerning the teeth and their disorders; however, they do not hesitate to inform the dentist that certain teeth must be extracted.

The dentist must be considered as a consultant rather than as a mechanic. Dentists are frequently able to save important teeth and to eradicate infection by means other than extraction. Both clinical and roentgenologic examinations of the teeth

should be made as the roentgen-ray may reveal the bony appearance to be fairly good when the condition is much worse clinically; on the other hand, roentgen examination may disclose lesions in a clinically 'clean' mouth."

The dentist has also erred, most frequently I think, in giving dietary advice which may be ill founded. The dark bread enthusiasts have aggravated many cases of colitis, for example. The dentist has an inferiority complex, if I may use that convenient cliché, regarding his medical knowledge and the physician perhaps has one too, regarding his understanding of dental problems. They may each misunderstand the other to the detriment of the patient. Assemblies such as this one tonight are an indication that they may meet on common ground and learn from each other.

Let us turn now to the point of view of the research worker concerned with dental problems. There are many aspects of investigative work which might be used as examples. The story of the recognition of fluorine as the cause of mottled enamel and later as a factor in reducing susceptibility to dental caries is a most interesting one. The developmental defects during tooth formation and their record of endocrine and nutritional disorders is another. I have chosen to present a very minute problem in enamel and dentin formation involving academic questions primarily and then to discuss the application of this work to the clinical problem of periodontal disease.

By a series of brilliant investigations, Wolbach and Howe^{2,3} demonstrated that vitamin C deficiency, scurvy, is characterized by inability of cells of mesenchymal origin to produce and maintain intercellular matrices. This effect was clearly shown in connective tissues of many types including the dentin of the teeth. In 1934, Fish and Harris⁴ described changes in the enamel-forming cells in complete scurvy but not in subscurvy. Their conclusion that "the failure of normal enamel formation, to which we find that vitamin C deficiency gives rise, may be of significance in the causation of human caries" attracted considerable notice.

You will remember that enamel is an epithelial tissue derivative and according to Wolbach and Howe, epithelial tissues are secondarily, but not primarily, affected in scurvy. It therefore, appeared important to investigate further this apparent failure of enamel formation in vitamin C deficiency. Briefly, we found that not only complete scurvy but various degrees of partial scurvy were accompanied in many instances by areas of defective enamel formation. These areas were, however, always sharply localized and related to damage to the overlying enamel organ. The greater part of the enamel was always formed in practically normal amounts regardless of the degree of vitamin C de-

ficiency.⁵ The rate of dentin formation, however, was found to be directly related to the amount of vitamin C given the animal.⁶ The areas of defective enamel were therefore concluded to be due to failure of the connective and bony tissues which attach the tooth to its socket. The enamel defects found in scurvy were considered to be secondary to changes in the connective tissues, as in other parts of the body. The hypothesis that scurvy may be of significance in the causation of dental caries appeared untenable because of extensive clinical and laboratory data as well as from our observations that the enamel was not primarily affected in vitamin C deficiency.

All this, I am sure you will agree, is very academic. This minor controversy served, however, to focus our attention on the mechanisms by which the teeth are suspended from the jaws and led to observations on the systemic type of periodontal disease which have been regarded as of clinical significance.

In discussing pyorrhea alveolaris or periodontal disease I mentioned that it was generally classified into two main types: one, a local type starting at the gingival crevice and the other, a systemic type involving first the bone and deeper soft tissue attachment. In the second type, the teeth become loose and migrate to abnormal positions, largely under the influence of occlusal stresses. The development of pockets and suppuration is usually a late complication and the gingival tissues for long periods may appear healthy upon ordinary clinical examination, although by x-ray the alveolar bone is greatly rarefied. Excessive occlusal forces of opposing teeth have been regarded by some as the etiologic factor. Efforts to produce the disease syndrome in dogs by the application of excess forces have been completely unsuccessful. In the partially scorbutic guinea pig, however, the essential features of the systemic type of periodontal disease were recognized. The important characteristics may be summarized as inability to withstand functional stress. Vitamin C deficiency therefore, has made available an experimental method of producing one type of pyorrhea alveolaris.⁷

Finally, I wish to say a few words about dental enamel. This tissue is the only normally calcified epithelial tissue in the body. By weight it is approximately 97% inorganic substance. It is so hard that it will give sparks when struck with steel. Microscopically it is composed of rods which are 5-6 microns in diameter, that is, approximately 5000 of them laid side by side, would measure an inch across. Because they are so hard it is extremely difficult to make sections of them which can be examined under the ordinary microscope. After treatment with acid it is even more difficult to retain structure which can be examined micro-

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THE MEDICO-DENTAL RELATIONSHIP*

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The time has come when the relation of dentistry to medicine should immediately be recognized as a genuine copartnership in the service of the public health.

The purpose of this essay is to focus attention upon the logic, the duty, the necessity of facing resolutely the fact that the healthy functioning of the human organism depends upon the effective care of *all* its parts, and to urge such a correlation of the ideals, policies and professional activities of medicine and dentistry as will promote the highest degree of well-being for both medical and dental patients. There is abundant reason for the ever-growing conviction that the public interest and welfare demand a more practical and uniform co-operation between the two professions, and that individual practitioners cannot fail to benefit by a cordial interchange of ideas and observations.

Knowing what we assuredly do know about the importance and usefulness of the united services of medicine and dentistry, their unalterable responsibility for the maintenance of complete physical health, their manifest duty in regard to the promotion of cooperative research and broader, more comprehensive teaching,— and comparing with this the little that we have actually done to develop a consistent, progressive and truly generous program of *national* scope both in professional education and in practice, must we not truthfully accuse ourselves of backwardness and indecision?

The potential value of the medico-dental relationship never has held and does not now occupy any conspicuous place in the mind or the conscience of either profession. Why must the individual genius, the cumulative knowledge, energy and experience, the organized power and influence which have accrued to both professions be still confined to separate channels, when one strong current would carry them both forward to regions of broader vision and finer achievement? What can be done *now* to release this magnificent power?

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Since the scientific world accepted the fact that diseases of the mouth and disorders of the teeth are grave sources of danger to the general health, the logical objective of enlightened leaders in dentistry has been a professional status in all respects equal to that of medicine—equal in educational opportunity, in united effort for scientific advancement, in altruistic acceptance of responsibility for safeguarding the public health, in freedom from all taint of commercial influence and mercenary practice, in proud and deserved enjoyment of the respect and appreciation of the community at large.

It is neither necessary nor practicable for the physician to be a dentist or the dentist to be a physician; it is necessary, and must therefore be made practicable for the two professions to co-operate in both education and practice, since science has decreed that they must henceforth consider themselves jointly responsible for the physical well-being of the private patient or the civic group for whom their services are demanded. Physician and dentist must therefore meet each other with a mutual respect based upon an equal degree of intellectual culture; a common knowledge of the biological facts which underlie their practices; and a simple recognition of the economy of effort which cooperation will ensure, since their problems of prevention, diagnosis and cure have much in common.

Since the acceptance of the focal infection theory, neither profession is complete in itself or competent to take over the functions of the other: but each is in duty bound to collaborate with the other in this common service, and should find itself impelled toward a common sympathy and understanding. In both professions the primary objective was formerly to cure; in both it is now to prevent; and *basic training* is therefore similar for dentistry and for medicine—a fact which naturally tends to friendly exchange of ideas and discoveries. The actual processes of arresting dental disorders, conserving dental structures, maintaining dental health and dental functions, preventing or postponing dental infections, belong to the practice of dental science as separate from medical science and require the dentist's special knowledge; but the possibility of focal infection, and the obvious fact that disease in one part of the body

may be the cause of or related to disease in other parts, must always suggest a pooling of knowledge and experience among physicians and dentists.

The complexities of such collaboration between medicine and dentistry need not be greater than they would be if dentistry were a conventional oral specialty of medical practice instead of an autonomous profession; and yet the potential reciprocal value of such an improved relationship has been, and continues to be, very slow to impress itself upon the consciousness of either profession. Instead of having a comprehensive program for the performance of common duties and to meet similar hazards (such as panel medicine and conveyor-belt methods of treating carious teeth), neither profession has received the necessary impetus to join the other effectively in a coordinate relationship to assure scientific treatment for the health of the human organism as a *whole*.

Dentistry is well prepared to receive and to confer the benefits of special knowledge, skill and experience in a program of coordinate health-service with medicine.

Modern dental education has been preparing the dental profession to meet its part of this obligation; but public understanding, recognition and support have not kept pace with the progress of dental science and dental professional ideals. For example, the public, which relies upon the judgment of its physicians and dentists, may not perceive that the principles of the basic sciences and their application in dental practice are definitely and positively in conflict with dental service of a purely mechanical nature, if that service is not successfully adapted to its possible effects upon living tissue. The dental schools are sending forth graduates who have been faithfully taught the same biologic sciences which form the basis of medical practice, and who may be expected to remember and apply their teachings as well as physicians do. Dentists owe it to the public and to themselves to emphasize this important fact as a feature of dental health-service, thus also demonstrating the close relationship between dentistry and medicine.

Having experienced for more than a century the tireless ambition, progressive improvement and inherent strength of our separately-organized profession, we believe that dentistry's continuance as an autonomous division of health-service is at least not inimical to the public welfare. The recent failure of the expensive and much-publicized Harvard Plan of dental-medical education, which so soon confirmed the prediction that it would prove abortive, adds force to the prevalent opinion that attempts to disturb dentistry's autonomy are unjustified on any ground whatsoever. This view is not only held by dental leaders in education and practice, but endorsed by many educators outside

of dentistry who have been observing the trends, experiments and acknowledged accomplishments of the past quarter-century.

All these academic attempts to merge dentistry into medicine have failed thus far; yet they have a significance which dentistry cannot afford to ignore since they indicate that the dental profession and its procedures are being subjected to critical examination by educators, philanthropists, and others, and also that close coordination of medical and dental health services, in education and in practice, is assumed by such persons to be natural and desirable.

All the newly-accepted responsibilities of dentistry, the raising of academic standards, the liberation of the dental press, the sponsoring of dental research, the persistent inquiry into ways and means of promoting steady growth in professional character, opportunities and attainments, were tending toward one natural goal—the honest interpretation and dutiful performance of dentistry's part in the maintenance of health. In the process of defining dentistry's part, it was inevitable that medicine's part, and the possibility of some *unfilled gap between the two*, should come up for consideration; in short, that dentistry's relation to medicine should become a problem of major importance, both in educational policies and in professional practice. Each portion of this problem has now received intensive study, and a considerable body of material has been accumulated to form the basis for a program of medico-dental cooperation. For such a program dentistry believes herself to be well prepared; on her part, the ideal of an acceptable medico-dental relationship is ready to take shape as a living and beneficent reality.

Dentistry has no long-standing prestige as a health profession comparable to that of medicine. The right kind of dental service in hospitals, which dentistry has been endeavoring to bring about, is still a new thing, of which comparatively few practising dentists have had any experience or advantage. There are still elderly practitioners (both in dentistry and in medicine) with little or no modern training in the basic sciences; and others, middle-aged, not sufficiently trained to utilize the sciences effectually in their professional procedures. The young graduates in dentistry, having the full benefits of modern training and environment, are confronted with current economic ideas and the temptation to over-extend through deputation some phases of the technical procedures of dentistry. The proposed medico-dental relationship should stimulate a wholesome rivalry with physicians in scientific achievement and advancement, thus minimizing the danger of impairing dentistry's professional autonomy.

With a common educational background, physi-

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cian and dentist will face their opportunities for public service in a spirit of mutual helpfulness, such as that already manifested by the American Medical Association in its recommendation of dental service in the hospitals. This trend reveals some of the joint responsibilities of physicians, dentists and their professional organizations in coordinating their activities with those of universities, hospitals, infirmaries and civic institutions.

Have you not the opportunity, here, to think and act so that the professional activities of common concern and interest to the physician and dentist are conducted in a coordinated program? Here and elsewhere it is but natural that the two coordinated divisions of health service should combine their forces and unite their interests in the common cause, maintaining a just balance in their relationship, guarding against undue interference, but above all making sure of their combined effectiveness in meeting both opportunities and obligations. Medical and dental science, medical and dental service, advancing together, expecting each other's assistance in all phases of activity, will ensure the utmost in professional growth, opportunity and accomplishment.

We have the best of reasons to believe that this ideal of association and cooperation is shared by the medical profession. Dr. Sydney R. Miller—Fellow of the American College of Physicians, Associate in Clinical Medicine, Johns Hopkins University, Associate Professor of Medicine, University of Maryland, Past-President of the American College of Physicians—speaking at the New Orleans convocation of the American College of Dentists (1935) said in part:

"No longer can there be intelligent doubt that public interest will not be best served unless there is interdependence and mutual respect between the medical and dental professions. Both groups need to understand each other better and learn how they can be of mutual assistance in dealing with the problems of disease. . . . Fortunately for all of us, and particularly the public, the practices of dentistry and of medicine have been growing steadily closer as experience has demonstrated the unavoidable interrelationship of their problems. . . . More aggressive efforts should be made to demonstrate, to both our professions as well as to the laity, that the medical and dental problems of prevention, diagnosis, cure, education and research possess much in common. Since neither profession is capable of the entire job, it logically follows that intelligent cooperative work is incumbent upon both professions"

In fairness to dentistry's record of achievement, is it not time to seek an intimate medico-dental relationship and to promote a detailed consideration of the form it should take? May I suggest (1) that

the problem be surveyed by a committee of representatives from the Rhode Island State Dental Society and the Rhode Island Medical Society, and (2) that this committee make a comprehensive study of all available data on the existing medico-dental relationship and of all available suggestions on what it should be, and present recommendations on how a medico-dental relationship that would be state-wide in scope and content and most desirable in quality could be attained.

The primary purpose of this proposed study, simply stated, should be to collect and coordinate data on all feasible plans for working cooperation between individual physicians and dentists in the promotion of effective health-service in every community, large and small, urban and rural in the State of Rhode Island. The sooner this purpose can be accomplished, the better. Are dental and medical leaders in Rhode Island and the members of the Rhode Island State Dental Society and the Rhode Island Medical Society willing to do their part in the attainment of this objective? If so, when?

MULTIPLE TRANSFUSIONS

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esting to note that he was given a transfusion of 500 cc. of whole blood in each arm at the same time from different donors. In addition to the above he was given a total of 5500 cc. of plasma, and another 1000 cc. of whole blood, all within seven days of the accident. During all of these transfusions he had one mild reaction which occurred immediately after receiving an intravenous dose of 40,000 units of gas bacillus antitoxin. As he was receiving a transfusion at the same time we do not know which caused the reaction. Three days after admission his red blood count was 5,120,000, hematocrit 49% and hemoglobin 13.5 grams. Following his first week after admission he maintained his blood volume with no evidence of blood destruction. Gangrene developed in his foot and a mid thigh amputation was performed without incident. He received in addition to the blood and plasma, gas bacillus antitoxin in 40,000 unit doses intravenously, and penicillin in 50,000 unit doses intramuscularly at three hour intervals for several days.

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MANIFESTATIONS OF DISEASES IN THE MOUTH

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scopically. One of our handicaps in the study of dental caries is that the initial phases occur in tissue which is most difficult to examine and little is known with certainty of the details of early stages of tooth decay. With the advent of the electron microscope, some progress has been made toward an understanding of the finer structure of enamel. The technique used up to the present time is borrowed from metallurgy. The enamel surface is ground and highly polished. It may then be lightly etched with acid. Following this an impression is taken with a film of a polystyrene and then a silica film is deposited on the impression. The silica film is then examined and photographed in the electron microscope.⁸ Quite recently the laboratory of the Radio Corporation of America, located at Princeton, New Jersey, has developed methods of dispersing finely divided material so that it may be examined. Only this past week, following this technique, I have been able to study fragments of enamel rods. The rods themselves are, as I will show you in the lantern slides, resolved into a number of building units. This investigation is obviously in its infancy but it certainly encourages us to speculate on possible future developments.

In summary then, we may say that the physician is primarily concerned with signs of systemic di-

sease as they manifest themselves in the mouth and with dental infection as it may cause or aggravate disease elsewhere. The dentist looks first of all for something that needs to be repaired. He is interested also, however, in the patient as a whole, in the effects of systemic disease on the teeth and surrounding structures and with the teeth as portals of entry of infection. Because of his success in educating patients to report at regular intervals for examination and treatment, he is in a position to detect early signs of disease which in turn may be called to the attention of the physician to the great advantage of the patient. The relation between physician and dentist is most satisfactory when it is on the same basis as that between the physician and the otolaryngologist or any other specialist.

Finally, the investigator concerned with dental disease has a field in which the problems are to a certain extent unique. Progress depends on a greater understanding of the phenomena of disease as manifested in the mouth and is often made possible by developments in other fields. The goal of research in dentistry is the control and prevention of caries and periodontal disease. As this goal is achieved, dentistry will not be eliminated but will continue its development as a specialty of medicine.

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PAUL C. COOK, M.D.

*President of the**Providence Medical Association, 1946*

DURING the past years I have heard many addresses made by incoming presidents of this Association, and I have read others which I have not been fortunate enough to hear. In the majority of cases the speaker's mood seems to have been made up of several components—appreciation of the honor conferred upon them, desire to do their best in conditions new to them, and a hope that they would be adequate to their new situation. These reactions seem to me to be normal ones, and I know that I am experiencing them. No man can know this society—its history, its accomplishments, its aims, the members who make up its fellowship—and not be deeply sensible of the honor of being asked to assume its leadership. The feeling of responsibility comes to me as it has to others—as they have done, I ask you to co-operate in the functioning of your society, to keep the officers informed of work that is being done by our members or by others of the profession, a report of which would be of interest at our meetings, and to express your opinions as to the type of programs you wish presented. As full attendance as is possible is desirable at all our gatherings, not alone for the benefits we may derive from the scientific part of the program, and the showing of appreciation and courtesy to the speakers, but also to increase the sense of solidarity and fraternity that should form a worthwhile part of our professional life. Your support of those to whom has been delegated leadership in the legal and business affairs of the Association has been loyal in the past and without question will remain so.

You will all agree with me that we have been

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fortunate in our leadership this past year. For many years Dr. Clarke has been a vital factor in the medical life of this city. The laboratory is the foundation upon which the efficiency of any hospital rests. Fortunately for the hospital with which he is associated, through his ability, his energy, and his vision, this foundation has been and is still being made increasingly secure and adequate to support whatever structure may be placed upon it in the years of progress that are ahead. Not alone has the hospital benefitted, but also the city and the state. As individual doctors we owe him much for his help in our problems. We are also grateful for his informative and always interesting talks at our meetings. I trust that it will not be long before he favors us again. A friend has been defined as one who knows the worst about us and likes us just the same. No one knows more about doctors than the pathologist who works with them. That Dr. Clarke has worked with us for many years and still was willing to serve us so well as President of this Association is indeed a proof of friendship.

There is a corollary to the air pollution problem which Dr. Clarke has discussed. It is that of pollution of Narragansett Bay. Clear air and clean water are fundamental benefits that unfortunately must be striven for in these modern times in urban areas. During the past few months there has been increasing evidence of public interest in the question. Last year a committee drew up a resolution stating the attitude of the society on the problem. I feel strongly that pollution of the Bay is an important health, recreational and economic problem, and that it is one in which the Providence Medical Association should have an active and continuing interest. I also feel that the opinion of this society should be made known to the proper authorities and to the general public, and that the influence of the Association should be brought to bear on the side of purification of the Bay. To take whatever action they deem advisable toward carrying out these aims, I appoint the committee which drew up the resolution mentioned, Drs. Chase, Cameron and Migliaccio. I am a Rhode Islander by adoption, not by birth, and I assure you that it is not necessary to grow up with Narragansett Bay to appreciate it. There is no need to say much of the benefits that would result from cleaning it up, nor the economic loss and the health hazard of its present state. Those who might gain the most would not be those to whom the Dunes Club, Quonochontaug or Seaconet are available. The youngsters of Wickenden Street, Fox Point and Federal Hill would profit if the upper bay were so purified that safe bathing facilities could be established within reach of these districts. Providence does not rank very high among comparable cities in recreational facilities—in time this condition could be remedied if the possibilities

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A NEW LEADER

On January first the Rhode Island Hospital began its seventy-eighth year of service to the citizens of this state with a new Executive Director and Superintendent, Oliver G. Pratt. As the largest general hospital in the state and the principal center of medical education and progress, it has done well to obtain the services of an administrator so capable.

During the last fifteen years, as Director of the Salem Hospital, Mr. Pratt not only has increased the usefulness of his hospital to its community but also has effected such cooperation with neighboring institutions that a real medical center was developed there and better medical education and therefore better medicine resulted.

A native of Salem, an alumnus of Massachusetts State College, Mr. Pratt studied in the Harvard Graduate School of Education, served as a Lieutenant of Infantry in World War I and became Director of Salem Hospital in 1931. He is a member of the American Hospital Association, past Vice-President of the American College of Hospital Administrators and past President of the Massachusetts Hospital Association, the Massachusetts Association for Occupational Therapy and the New England Hospital Assembly. He is a member of the Editorial Board of "Modern Hospital" and of the Board of Directors of the Massachusetts Hospital Service Inc. (Blue Cross) and Medical Service (Blue Shield). He also served as Senior Hospital Administrative Specialist of

the United States Public Health Service—covering war time appointment as State Hospital Officer for Civilian Defense (1942-1944).

The Journal is happy to welcome Mr. Pratt to Rhode Island. The aftermath of war, with the scarcity of nurses and other shortages, constitutes a problem which is difficult and discouraging to all in the field of hospital management. In the face of this challenge and with the plans for the new hospital building under way he faces a situation in which his professional skill and experience are needed. In leading the way to the establishment of a really great medical center here he has the eager support of the profession.

WHAT'S IN A NAME?

The news bureau of the Railway Express Agency reports the story that recently an air express shipment for Buenos Aires came to the New York agency marked "Hydroxymercuripropanolamide-orthocaboxyphenylacetone". The shipping clerks threw away their dictionary and conferred. The package soon went zooming to its destination labelled "chemical products".

In what is called the atomic age, a time when even the man in the moon is not immune to the touch of radar, the action of these express clerks in reclassifying the title of their problem is most refreshing. Think of the hours they might have expended in research had they not resorted to the simple expedient of descending to the vernacular

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to expedite the passage of the package entrusted to their care.

There isn't much doubt that the average man is very appreciative of the scientific contributions in recent years aimed towards bettering his all round existence. But this matter of scientific terminology, invading with increasing freedom the vocabulary of the ordinary man, is certain to tax his restraint against shouting out the cause of basic English. Like the railway clerks mentioned, he has struggled with the question of where to place the accent on sulfanilamide until science came along with a host of sulfa derivatives for common use. Then to add confusion, penicillin, with its first two "i's" offering a challenge to him who would pronounce accurately, emerged from the mold.

The situation can be most serious. It is not like the pedantic problem of whether to adopt the Anglo-Saxon "understand" in preference to the Latin "comprehend". It goes far deeper into the question of human relations. Imagine the embarrassment of the seemingly educated person who is humiliated by the drug clerk correcting his pronunciation of one of the new drugs. Or consider the plight of the pharmaceutical company which might be forced to advertise to the public to buy its brand of "Sulfy" or "Penny" lest the average citizen shy away from the task of pronouncing the official title.

Oh, well, Spring is not far away, and truly a rose is as sweet by any other name. And while American ingenuity continues to survive the problem will probably be met with the skill of the railway clerks who settled for "chemical products" to the satisfaction of all concerned.

SURVEY OF CHILD HEALTH CARE

The American Academy of Pediatrics is conducting a nation-wide survey, on a state level, of health facilities for children in the postwar period. Already this survey is being carried on in North Carolina which was chosen as the pilot state.

It is the first attempt on the part of an organized group of medical men in each state to inquire into its own practices. It is a fact finding study to determine our own strong and weak points in child health care. Every pediatrician and practitioner in the state will be expected to help in this survey.

The survey must include pediatric and general practice, hospital facilities, dental care, nursing facilities—urban and rural, baby welfare activities, state, city and town health functions and social agency facilities.

Questionnaires will be sent in due course and it is hoped that these will be treated with respect, carefully answered and not relegated to the waste basket with advertising material. If all will cooperate, the task imposed upon the executive secre-

tary of the Academy will be facilitated, fruitful and lead to a proper functioning of all child health medical facilities.

The importance of this survey rests on the simple fact that if the members of the medical profession in the State of Rhode Island cannot set their own house in order, some other agency will conduct the survey and we may or may not be asked to participate in the planning for the future health of children in our own state.

The Maternal and Child Health Act of 1945, S 1318, the so-called Pepper Bill, provides complete medical services for "All mothers and children in the State or locality who elect to participate in the program" regardless of financial status. Under the title children are considered as all individuals from birth to 21 years of age. The age limit of 21 years as expressed in the act demonstrates the fact that this is not a pediatric problem alone but that every physician in the State of Rhode Island will be affected by the stipulations of the act.

The survey will be conducted by Dr. John H. Hubbard with an office in Washington. Dr. Hubbard is a member of the American Academy of Pediatrics and has been appointed by this organization. Each State Chairman will be responsible to him. Dr. William P. Buffum, State Chairman of Rhode Island, will supervise the survey in this state.

THE PRECEDENT IS ESTABLISHED

The action of the Catholic hospitals in Michigan in resigning from the Blue Cross organization recently focuses attention anew on the manner in which a dangerous precedent can be established by a governmental bureau once it is given leeway to establish regulations by administrative law.

In this instance, so we are informed, the trouble stems from a ruling made by the Children's Bureau of the Department of Labor in the administration of the Emergency Maternal and Infant Care program. In allowing funds to the States the Bureau permitted hospitals to make their charges on their per diem operating cost, but it made its own regulation that the nuns serving as nurses, and in other capacities, in the Catholic hospitals, were volunteers and their work was not compensable. Why this ruling was allowed to prevail, even in spite of the fact that the EMIC was presumably a wartime measure, is difficult to understand. But prevail it has.

Now along comes a revitalized Veterans Administration medical and surgical department that seeks to provide the best care for the veteran, and is ready to meet all fair costs for that care. This is no emergency program; it is a long range plan calling for the utilization of available hospital facilities in local communities. The Catholic hospitals offered their assistance and submitted their

complete per diem cost which the Veterans Administration reportedly found acceptable. However, the Bureau of the Budget stepped into the picture to rule that the previous provision relative to the inclusion of the services of the nuns in the operating costs of the Catholic hospital prevails also for the Veterans program.

Perhaps the Catholic hospitals of Michigan should not have withdrawn from Blue Cross. Yet, since the Veterans Administration plans to enter into contracts for the care of the veterans with the Blue Cross which in turn would sub-contract its member hospitals, the Catholic group apparently felt that it had no alternative.

If we are informed correctly of this problem we venture the opinion that it goes far beyond the mere payment of the full per diem hospital cost of the institutions involved. It looms as an issue to determine the scope of bureaucratic authority to establish, by administrative right, patterns that are not consistent with regular community practices. The Catholic hospitals by this recent action have openly challenged the precedent established by the Children's Bureau. Their action will not be without wide support throughout the country.

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of the Bay could be realized. I believe that no state in the Union has received from Nature a more glorious heritage than Rhode Island has in Narragansett Bay. Let us strive to restore it to a better condition, and to keep it a source of health and of pleasure for ourselves and our children.

During the past few years medical practice in Providence has suffered because of the absence of a large percentage of our best men in the armed services. Those of us who have remained have to some extent been forced to make one of two decisions—to limit the number of patients seen or to reduce the amount of time and study given each patient. The results have not been satisfactory to either the patients or ourselves. We have not been able to give the service we would have liked to give. We have been to much tempted to cut corners in our work. As doctors we are sufficiently realistic to know that our increased activity—and prosperity—has not been entirely due to our professional skill or to our personalities, but to the fact that many good men were unavailable, having gone where their country needed them. These men are now coming back, and their return is the best thing that could happen to the practice of medicine here. If we who have remained have allowed ourselves to lower our standards under pressure, it is our duty to correct the fault as that pressure is removed. The profession for its own good needs the healthy stimulus that the returning veterans are beginning to provide. During the coming year it is the foremost duty and privilege of all of us, individually and collectively as an Association, to welcome back those who from patriotism took the harder road and served with our armed forces with little regard to their own comfort or safety. This welcome should not be vocal only. Whatever we can do to help them in the re-establishment of their practice, or in its initiation, as we hope that some new men, returning will choose to live and work with us, let us do with a will. We are proud of their record. If we can be of some aid to them at this time, it is our privilege. We are glad they are coming back, and we are eager to work with them for the improvement of medical practice and service in Providence.

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SURGERY IN RHODE ISLAND

JOHN E. FARRELL, A.B.

Executive Secretary, Rhode Island Medical Society
and the Providence Medical Association

The following article on the question of surgery in Rhode Island first appeared in the MEDICAL NEWS of the Providence Medical Association, Vol. 2, No. 8, August, 1941. In view of the proposal for a voluntary prepaid surgical insurance program now in Rhode Island it appears pertinent to reprint this interesting discussion

THE EDITORS

quences of surgical procedure upon that individual.

Dr. S. S. Goldwater of New York forcefully presented this viewpoint years ago when he wrote¹ that

"A major operation is a severe or serious operation, not a slight or trivial one, but from comparatively trivial surgical procedures serious consequences sometimes result. The test lies in the gravity of the operation, which must be gauged not merely by the technical difficulty of the procedure, but by the risk to the patient; and in using the term risk I am thinking not only of the risk to life, but of the likelihood that any important bodily function may be impaired."

"Elements to be considered are: the scope of the surgical procedure; the danger of shock; the presence of known complications, which add to the risk the probability or possibility of unsuspected pre-existing surgical complications; the probability or possibility of postoperative complications; the probable duration of the operation; the age and general condition of the patient (presence of intercurrent disease, not directly related to the operation); the degree of mutilation; the amount of pain or mental anguish caused; the nature of the anesthetic used, and the risk of legal complications in the case of an unsuccessful result."

"It will not do, for example, to say that a tonsillectomy is a minor operation; it might well be this in the case of a healthy child, and especially if the operation were performed without a general anesthetic. It would scarcely be so in the case of a complete tonsillectomy performed under anesthesia on a person of advanced years (as many a sufferer will testify). But even the most hopeful form of tonsillectomy, in the most promising type of patient, can result (and occasionally does result) in lung abscess. Similarly, the removal of hemorrhoids may properly be classified as either a minor or major operation, according to the circumstances. Moreover, the very slightest surgical interference, if performed without due regard to asepsis, obviously involves a risk out of proportion to the ordinary rating of the procedure."

That the term minor surgery is in disfavor with medical authorities was pointed out in the American Medical Journal² by Hubert A. Royster who made

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If there is one term in medical and hospital usage which approaches the Shakespearean dilemma of "to be or not to be" it is the expression major and minor surgery. Just where the line of demarcation lies between the two branches, if such a division is proper, no one has authoritatively determined. The Rhode Island statutes have legalized osteopathic physicians and chiropractic physicians with a restraining clause that they "shall not practice major surgery", but any inference that such wording grants rights of operative surgery in minor procedures to these physicians is a presumption that warrants consideration by the courts of the State.

It would appear that the medical concepts of what constitute major and minor surgery depend upon the individual point of view. Is an operation a major one because it is performed in a hospital? Because it is costly? Because it is possible only under a general anesthetic? Because it is a difficult step for the surgeon? Or because it places the patient's life in jeopardy?

Affirmative answers to all these questions might be justified at one time in medical progress, but hardly at present. Today more and more serious operations are being performed with the use of local anesthesia, and the hospital is used far more freely, and willingly, by the public than heretofore. Modern scientific procedures and discoveries have played their part in decreasing the risks attendant upon operations with the result that the average patient no longer views surgery as a last desperate attempt to prolong his life.

The simplest and least hazardous surgery is a major procedure to most patients, and especially to those persons of a nervous makeup. Therefore one can only make the division between so-called major and minor operations by careful consideration of the individual person, and the possible conse-

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SURGERY IN RHODE ISLAND

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the plea that the term be eliminated because of possible implications. He advanced the arguments that "only one of 104 surgeons whom he consulted believed in the division of surgery into major or minor. The principal objection to the term, it appears, is that it is vague and ill-defined. There exist no definite criteria by which to designate any one procedure as minor or major. What appears to be a simple procedure may develop into a most complicated one. What is a minor operation in the hands of a skillful surgeon may prove a major one in the hands of the unskilled surgeon. Such criteria as time required to perform an operation, the mortality, the skill required, the question of anesthesia, the question of whether it can be performed in the office or requires hospitalization are all variables. The suggested substitutes for the term minor surgery, such as office surgery, ambulant or dispensary surgery, are hardly an improvement, (for) all surgery is based on the same fundamental principles and is therefore not divisible. In no other field of medicine does a similar division into major and minor procedures exist. Actually the term minor surgery has largely disappeared from the curriculums of our leading medical schools."

One of the few attempts made by legislative groups to answer this puzzling question is that of the Board of Regents of the University of the State of New York (State Education Department) which attempted to clarify the 1939 amendment to the New York osteopathic law whereby osteopaths are permitted to "use instruments for minor surgical procedures" if they can satisfy the Board of Regents that they have had sufficient instruction and training. The definition arrived at by the Board stipulates that "The phrase minor surgical procedures, as used in the law, shall be construed to include all surgical procedures, excepting those involved in incision for: the opening of a natural body cavity, the removal of benign or malignant tumors, bone fractures, the amputation of extremity or an appendage, the removal of any gland or organ or part thereof, or plastic surgery of the human body."

In view of this very apparent lack of understanding and legal interpretation of what constitutes major and minor surgery for the medical man it is difficult for one to realize upon what grounds the Legislatures in 1927 and 1931 saw fit to adopt the amendments to the statutes relating to the practice of osteopathy and of chiropractic to provide that neither group of healers "shall practice major surgery."

It is a fundamental principle of statutory construction that the Legislature must be presumed to have had in mind all previous legislation upon

the subject, and the application of this principle regarding these amendments offers the only conclusion that the Legislature was merely taking cognizance of the fact that manipulative surgery was encompassed in the theories of practice of these healers. Certainly the Legislatures of 1927 and 1931 must have known of the initial statutes licensing osteopathy and chiropractic in this State, in both of which opposition to any surgical procedures other than such as might be performed by manual manipulation are expressed. That any invasion of the field of operative surgery was intended is indeed a rash presumption.

When osteopathy was recognized by legislative enactment in Rhode Island in 1914 the practice was clearly defined,³ and the definition still prevails, that it is "to be the treatment by manipulation of diseased or abnormal conditions of the human body." And the first chiropractic legislation in this State,⁴ passed in 1927, defined chiropractic as "the science of palpating and adjusting the articulations of the human spinal column by hand, for the elimination of the cause of disease, corrective and orthopedic gymnastics, and dietetics."

Subsequent legislative acts have been construed by healers in these groups to have granted them operative surgical privileges, but such presumption will hardly stand the test of challenge. The amendment to the osteopathic law⁵ passed in 1927 provided that an osteopath who can satisfy the division of examiners that he has completed a year of post graduate internship in a hospital approved by the division may be granted a license "to practice any branch of surgery." This reference to "any branch of surgery", poses another question. Are we not to presume that the Legislature meant any branch of *manipulative* surgery in view of the teaching and theory of the practise of osteopathy? Or are we to presume, as the osteopaths would have us do, that this wording removes the restriction relative to major surgery, and that the all inclusive "any" allows them to enter the field of operative surgery to which they are opposed in theory?

Our contention that any invasion of the field of operative surgery is an invasion of the field of medicine is borne out in the opinion handed down by the Supreme Court of the State of Nebraska⁶ last May (1941) when it ruled that osteopaths may not practise operative surgery. This Court stated in part that

"The word 'surgery' used in its general sense in connection with the profession of osteopathy means surgery by manual manipulation and was never meant to include operative surgery as we now understand it. The correctness of this statement is evidenced by the very principles of osteopathy to the effect that the general use of a knife or other instruments in surgical operations was regarded

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SURGERY IN RHODE ISLAND

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as unnecessary and opposed to the osteopathic system of treatment. The practice of osteopathy and operative surgery has long been recognized as two separate and distinct things. Separate boards have been set up in this state for the examination of those applying for licenses to practice medicine and surgery and those desiring to practice osteopathy. It is urged that the principles of osteopathy have changed and that experience and learning have produced certain advances that must be recognized. If osteopathy has changed merely by a self-serving attempt to broaden its scope by invading fields requiring a different license, we can only say that the legislature has never recognized any such additions to the profession. If the changes are the result of advancements in the profession, of course, they still constitute the practice of osteopathy. But the practice of operative surgery by an osteopath is an invasion of the field of the physician and surgeon as it is generally known and is not an evolutionary advancement of the profession of osteopathy. *State v. Gleason*, 148 Kan. 1, 79 Pac. (2d) 911; *Burke v. Kansas State Osteopathic Assn.* 111 Fed. (2d) 250."

This conclusive court opinion might well be applied to a study of our statutes, for osteopathy and chiropractic stem from basic sources, and the practices are fundamentally the same in Rhode Island as in other states. The mere fact that branches of medicine and surgery may be taught to increase the knowledge of the student in the anatomy and functions of the various parts of the human body, for the purpose of better fitting him to practise osteopathy or chiropractic, does not warrant him to invade either medicine or surgery on the theory that they constitute his practise. The scope of osteopathy and chiropractic are well known, and schools and colleges teaching these theories must stay within their boundaries.

The law may be poorly phrased, but the main fault lies in the unrestricted freedom in the interpretation of it by those whom it would govern and restrain. The Rhode Island Supreme Court might well consider the particular phraseology to determine the intent of the Legislature, and at the same time to dispel all doubt as to what constitutes the field of surgery.

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COMMUNITY NEEDS AND THE HOSPITAL FUTURE

OLIVER G. PRATT, *Executive Director, Rhode Island Hospital*

THE people of Rhode Island may anticipate a comprehensive and most modern hospital system designed to meet every health need.

The medical profession and the philanthropists have set a pattern for leadership in health service for all the people of this State. In recent years the Blue Cross organization has been introduced to aid in removing the financial burden by providing a means for budgeting for hospital care. The success of this movement is attested to by the fact that the Rhode Island Hospital Service Plan leads the nation in the percentage of people served, having enrolled fifty percent of the population.

Great advances have been made in the science of medicine. The challenge for tomorrow is to correlate preventive and curative medicine more completely, and to develop a hospital system that will assist in making this combined scientific and life-saving service readily available to all.

Today we find specialists grouped in urban centers partly because of the need for working with their colleagues in other specialties, but also because there is adequate clinical material. The ratio of population to certain medical specialists has been rather definitely defined. Experience indicates that the Radiologist can serve from 50,000 to 75,000 people, and the Pathologist can serve up to 100,000 people. With our present lack of a hospital system this medico-economic factor plays a real part in limiting the availability of modern medical practice.

This example alone indicates the wisdom of developing a hospital system that will redound jointly to the benefit of the physician and the patient. Many other reasons for correlation of the work of hospitals which would be in the interest of the physician and patient alike are obvious to the members of the profession.

Rhode Island lends itself very readily to a state-wide voluntary demonstration of cooperative effort for distribution of medical service to all its people.

The concentration of population, its size, the location, leadership and quality of existing hospitals, the acceptance of Blue Cross, the leadership of the Medical Society in developing a voluntary pre-payment medical-surgical insurance plan, the interest in and appreciation of the value and frank necessity of continuing medical education, the presence of universities together with the interest of their officials and faculties, and the willingness of business leaders and individuals to contribute generously, are each important factors. When correlated they will provide the basis with which to create a system of hospitals capable of meeting every health need of all the people of Rhode Island, and which may well set a pattern for the country.

The benefits which will accrue may be detailed briefly as follows:

1. The mechanics will provide for a program of continuing and comprehensive medical education for all physicians including supervised resident training in the smaller hospitals. (An adaptation of this plan is today aiding in providing educational opportunities for physicians returning from service with the armed forces).
2. All medical services will be available to all patients in all hospitals by a mutually agreeable consultation service.
3. Smaller hospitals and health centers with the assistance of necessary specialists can provide the mechanics for taking preventive medicine and diagnostic service to the people. The average citizen will travel a long distance to secure medical attention only for an acute illness.
4. Planning and correlation will avoid duplication of capital outlay, and equally important it will provide more economical service for most patients.

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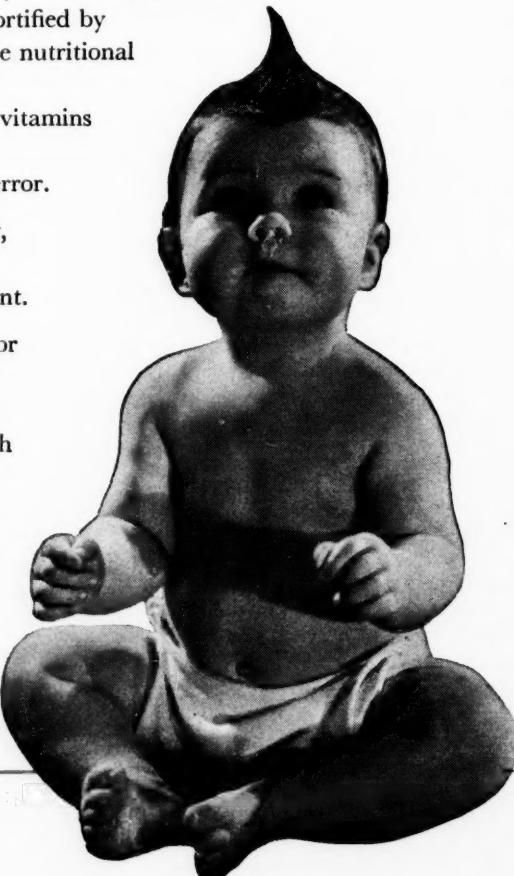
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COMMUNITY NEEDS AND THE HOSPITAL FUTURE

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5. There will be an improved quality of service in all hospitals. The smaller hospital will benefit by the availability of specialists and laboratory and X-ray service from the larger hospitals. The larger hospital will be able to do more for its patients because it will receive only the very complicated cases, carefully screened at the local hospital.
6. There will be greater opportunities for research and for standardization of certain elements of hospital management.

The hospital field has developed rapidly in the last decade, but there have been many limiting adjustments during the last five years. We are not going back to the pre-war pattern. We are going forward to a new type that will better serve all the people. We will need all our wisdom, maturity and foresight to gain our objective.

Physicians, hospitals and the people they serve must agree on certain policies to insure success.

1. The accepted patient-physician relationship must continue.

2. There must be an inherent desire to care for the patient in his home hospital and to move him to a hospital in a larger center only when it is in the interest of the patient.
3. Every effort must be made to develop the outlying hospitals.
4. The voluntary coordination of the work of hospitals must be on a firm foundation. The development must be from the "grass roots" up rather than from the top down.

The American people are profiting by the best medical care and hospital service available in the world. From what started as merely custodial care we find the voluntary hospital becoming a medical and health center, an institution devoted to education and research as well as to the diagnosis, care and cure of the sick.

The individual voluntary hospitals are doing remarkable work today. The future development will be to weld the individual hospitals into a system of hospitals. Tomorrow we can anticipate that a voluntary system of voluntary hospitals will make available to all the people a type of hospital service which will parallel in scope and quality the ever increasing scientific and complicated health and life-saving service of the medical profession.

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THE OBLIGATIONS OF AN INTERNIST TO A GENERAL SURGEON*

THOMAS FINDLEY, M.D.

The Author. Thomas Findley, M.D., of New Orleans, La. Assistant Professor of Clinical Medicine, School of Medicine, Tulane University and Director of Section on Internal Medicine, Ochsner Clinic.

AN internist has been defined as a man who is totally unable to answer either yes or no to any question. The definition was made in jest but there is much truth to it. If there is such a thing as a typical internist, he is a sedentary individual, curious, skeptical, reflective. He is accustomed to look at the patient as a unit rather than as a collection of separate organs and, if he has had the fundamental scientific training he should have had, he is eager to distinguish between a fact and someone's opinion. Although often powerless to suggest an alternative procedure, he regards every operation as an exercise in violent therapeutics and a confession of failure to cure. He is, however, humble before the complexities of modern surgical technique. His fees are not such as to command general admiration.

The surgeon, on the other hand, is a man of action. He lives in an exhilarating world of knives, blood, and groans. His tempo is of necessity rapid. He is inclined to look at his less kinetic colleague with an air of puzzled condescension but may, in a relaxed moment, admit that the medical man is occasionally able to assist uncomfortable dowagers in the selection of a cathartic. Accustomed to legerdemain and quick results, he is apt to regard the diagnosis and treatment of a headache, for example, as a trivial matter, forgetting that the internist may require hours of probing before discovering that what the patient needs is not a new pair of glasses but a different mother-in-law. The surgeon and the internist are workers in the same vineyard, but their points of view are inevitably different.

Of those patients who come to any clinic for help there is a certain small percentage who present definite and well-demarcated problems—a broken arm, a decompensated heart, a gravid uterus, for example. Of these the internist will claim his share and do what he can. Over and above these, however, is a larger number with ill-defined complaints who tax the resources of the entire staff. These

are the ones who are commonly x-rayed from head to toe, whose fluids and excrements are examined with great skill, into whose every orifice electric lights are inserted—to no avail! The standard reaction on the part of the medical attendant then is that of anger. The patient is automatically regarded as an imposter who has no right to his symptoms and his visit to the clinic is looked upon as a nuisance and an intrusion. Actually, of course, these are perhaps the sickest people we see. It may be argued that they are merely suffering from such elemental emotions as grief, frustration, inadequacy, fear, or sorrow, that their problems are therefore non-medical, and that the clinic is not required to help them. If this is so, we are amateur physicians indeed.

W. R. Houston has frequently and eloquently pointed out that sickness of any sort carries with it a curious and sometimes irresistible demand for action. There is nothing to which a sick man will not submit himself—he is gladly purged, puked, bled, transfused, sweated, infused, cut, frozen, heated, and shocked and he will swallow literally anything. It is seldom that the consequences of these actions are considered, for it is action itself that is demanded. Even the most normal of us howl and gyrate when thrust suddenly into pain; these actions serve no useful purpose whatever, but somehow they seem to bring relief.

And so these people come to us in their distress demanding both action and relief. This demand comes not only from the patient but from the family as well. One can never enter a sickroom without being immediately aware of immense forces at work. The urge to violence is often so compelling that it requires great courage to follow the wiser course and do nothing. Certainly it is a commonplace experience for patients to complain that we have found nothing for which to operate upon them, and it is no consolation to these people to be told that their roentgenograms and blood tests are negative. It is another curious fact that no one minds being told that he has something wrong with one or more of his organs, but he bitterly resents the implication that the trouble lies within himself. A heart that is failing a little, a sluggish liver, a pair of weak lungs—these are cherished and respected ailments—but a personality defect is accepted with the greatest reluctance.

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OBLIGATIONS OF INTERNIST TO A GENERAL SURGEON

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In dealing, as it must, with individuals whose primary difficulty is emotional, a clinic finds itself in a peculiarly dangerous situation because a certain percentage of these patients will inevitably present some physical abnormality which, in a more stable host, would be a legitimate surgical target. The diagnosis of anxiety state, chronic reactive depression, or conversion hysteria is not made by exclusion, however, and it would be a major error

to assume that an elderly housewife could not have a psychogenic backache and a fibroid tumor as well. The surgeon often accuses the internist of complacency and ignorance when he chooses to ignore a uterus which is not quite perpendicular, or a solitary gallstone, or a pair of tonsils from which a fluid of unknown composition can be expressed. There are certain people, however, who demand violence; the surgeon enjoys removing organs and one function of the internist is to see that these two never meet.

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Ralph DiLeone, M.D.

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MEDICAL OPINION IN RHODE ISLAND

Report 3.

PREPAID HOSPITAL INSURANCE

Prepared by the

COMMITTEE ON POSTGRADUATE EDUCATION

**Alex M. Burgess, M.D., B. Earl Clarke, M.D., Harmon P. B. Jordan, M.D.,
Elihu S. Wing, M.D., and John F. Kenney, M.D.**

THIS is the third of the summaries of medical opinion based on answers to the questionnaire sent to all members of the Rhode Island Medical Society in April 1945. The previous article dealt with Diagnostic Centers and Group Practice. This communication is concerned with the answers to question No. 18 which reads as follows:—

What is your opinion of:

- (a) The Blue Cross Plan for hospitalization?
- (b) Compulsory hospital insurance for employed workers?
- (c) Expanding the use of existing voluntary hospital insurance organizations?

As in the case of many of the other questions several replies were received in which question 18 was either wholly or partly unanswered but nevertheless there were only nine in which part (a) concerning the Blue Cross Plan was ignored. The results are as follows:

In favor of the Blue Cross Plan—159
Opposed—9

Of the 159 who expressed themselves in favor of the plan 80 were evidently enthusiastic and used such expressions as "excellent" or "ideal" or the like to indicate more than mere approval. Of those who opposed the plan two stated that it was "oversold" and six that they believed that no more memberships should be sold until more hospital beds are available. The lack of hospital facilities is shown by the statement of one physician that the plan "cannot deliver the goods". Other unfavorable comments are of interest. Several show a feeling that the benefits should be increased in one or more particulars, "Should cover X-ray, operating room, etc.", "Not adequate, should provide longer periods of hospitalization", "X-rays should be included", "Should be expanded to include a reasonable fee for the attending physician." The possibility of abuse of the service is suggested by these statements: "Fills up hospital beds with those who don't need hospital beds" and "a few patients try to be hospitalized to recover minor benefits." One other interesting comment was made in regard to

the plan, a physician stating that it is "fraught with danger to a self governed medical society since it can completely dominate all participating hospitals many of which are governed by lay persons." Despite all the above criticisms, some of which indicate problems and difficulties with which the Blue Cross has to contend, it is evident that the local profession is enthusiastically in favor of the plan.

A tabulation of the answers to part (b) which deals with compulsory hospital insurance gave a somewhat unexpected result. It is generally supposed that the medical profession is very strongly opposed to compulsory insurance and yet of the 125 answers to this question, 50 were in favor of this form of insurance while 75 opposed it, a proportion of only 3 to 2 in opposition. Favorable comments included the opinion that it is "bound to come" and "possibilities good if kept out of political control and out of the general treasury of the state." Six physicians indicated enthusiasm by the word "excellent" or the like. Several of the majority group who opposed compulsory insurance were also emphatic. The commonest objection was that compulsory insurance constituted an "infringement on the rights of an individual", was "undemocratic" or "socialistic."

The answers to part (c) indicated a strong opinion that the use of existing voluntary hospital insurance organizations should be expanded. Of the 122 replies to this question 114 were in favor of this expansion and only 8 opposed. 8 of those in favor of such expansion indicated enthusiasm in their comments. No unfavorable comments of interest were noted.

In summary, then, we may say that the local medical profession, as represented by the group who answered the questionnaire, has expressed very strong approval of the Blue Cross Plan and are of the opinion that existing voluntary hospital insurance organizations in general should be expanded. In regard to compulsory hospital insurance for employed workers the profession, as judged by this group, is opposed, but by the rather narrow margin of 3 to 2.

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IT is one thing to *read* results in a published research. Quite another to see them with your own eyes.

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But may we suggest that you make your own tests?



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*N. Y. State Journ. Med. 35 No. 11,590
Laryngoscope 1935, XLV, No. 2, 149-154

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DISTRICT MEDICAL SOCIETY MEETINGS

PROVIDENCE MEDICAL ASSOCIATION

The Ninety-ninth Annual Meeting of the Providence Medical Association was held at the Medical Library on Monday, January 7, 1946. The meeting was called to order by President B. Earl Clarke at 8:30 p. m.

The Secretary read the records of the previous meeting of the Association which were accepted and placed on record. The Secretary presented the Annual Report for the year 1945 which was accepted and placed on record.

Dr. Herbert E. Harris, Treasurer, submitted his Annual Report for the year 1945 which was accepted and placed on record.

The President introduced Dr. Charles L. Farrell of Pawtucket, a member of the Board of Directors of the American Association of Physicians and Surgeons, who briefly outlined the objectives and programs of that association.

The Secretary reported for the Executive Committee as follows:

That it had received a proposed budget prepared by the Treasurer for the operation of the Association in 1946, calling for a total expenditure of \$6,842.

That the Executive Committee recommends the annual dues for each active member in 1946, exclusive of members in service with the armed forces, be \$15, and for associate members, \$5.

Dr. Harry C. Messinger moved the acceptance of the report of the Executive Committee and the approval of the recommendations submitted to the Association. The motion was seconded and adopted.

Dr. B. Earl Clarke delivered his presidential address, in which he reviewed the work of the Association for the past year. He stressed the necessity of continuing the Smoke Abatement Committee as a permanent committee which should be sure to see that interest does not lag in the long-term program necessary to accomplish results. Dr. Clarke advised that our members of the House of Delegates of the Rhode Island Medical Society should organize and should report back to the Association regularly.

Dr. Clarke presented a most scholarly and profound exposition of the present trend in the matter of Social Security. For various reasons the practice of medicine and practitioners of medicine have

been thrown into the center of the current in this stream of change. Like a swimmer in trouble, the medical profession has grasped at something or anything for help in the situation. This "something" is voluntary prepaid medical care. Dr. Clarke does not consider its development as a satisfactory or complete answer to the situation.

Dr. Clarke made a plea for individual initiative and for the placing of spiritual values above material ones as being the only satisfactory answer to many present-day problems. Our retiring President's able speech is worthy of widespread re-publication.

The President called for nominations for the President of the Association for 1946. The Secretary reported that the Executive Committee had recommended the nomination of Dr. Paul C. Cook, and he stated that there had been no counter nominations. It was moved that Dr. Cook be elected President of the Association. The motion was seconded and unanimously adopted. Dr. Clarke appointed Drs. Jesse P. Eddy, III and Edward S. Cameron as a committee to escort the new President to the rostrum.

Dr. Cook expressed his appreciation to the membership for the honor bestowed on him, and he briefly outlined some of the problems which he felt warranted the attention of the Association in the coming months.

Dr. Cook stressed the need for improvement in the matter of pollution of the waters of the Narragansett Bay and the rivers of Rhode Island. He appointed a committee to report on this matter after investigation. Dr. Cook spoke at considerable length concerning the problems of returning veterans and extended to them a warm welcome. Their help is greatly needed in providing adequate medical care of high standard.

Dr. Cook called for nominations for the office of Vice President. The Secretary read the slate of officers recommended by the Executive Committee and stated that there had been no counter nominations. Dr. Clifton B. Leech moved that the entire slate as recommended by the Executive Committee be adopted. Dr. Jackvony seconded the nomination, and it was unanimously passed. The Secretary was authorized to cast a vote to elect the entire slate

continued on page 149

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PROVIDENCE MEDICAL ASSOCIATION
continued from page 147

of officers to serve the Association in 1946, as follows:

President	PAUL C. COOK, M.D.
Vice President	GUY W. WELLS, M.D.
Secretary	FRANK B. CUTTS, M.D.
Treasurer	WILLIAM P. DAVIS, M.D.
Executive Committee	{ B. EARL CLARKE, M.D. FRANK W. DIMMITT, M.D. (2 members for 5 year terms)

Trustee of R. I. Medical Library,	HERBERT E. HARRIS, M.D.
-----------------------------------	-------------------------

Delegates to House of Delegates
of R. I. Medical Society:

B. H. Buxton, M.D.	A. E. Martin, M.D.
H. G. Calder, M.D.	A. H. Jackvony, M.D.
A. V. MIGLIACCIO, M.D.	B. E. Clarke, M.D.
A. H. Fox, M.D.	P. C. Cook, M.D.
A. Giura, M.D.	P. P. Chase, M.D.
A. M. Burgess, M.D.	J. L. Belliotti, M.D.
E. M. Porter, M.D.	R. H. Whitmarsh, M.D.
H. E. Utter, M.D.	F. Cutts, M.D.
G. W. Davis, M.D.	W. P. Davis, M.D.
K. K. Gregory, M.D.	W. Horan, M.D.
E. V. Famiglietti, M.D.	P. I. O'Rourke, M.D.
P. F. Harrington, M.D.	R. Baldridge, M.D.
F. I. Matteo, M.D.	G. Waterman, M.D.
E. W. Bishop, M.D.	H. A. Lawson, M.D.
G. E. Crane, M.D.	

The President stated that the reports of the various standing Committees of the Association had been submitted to the Secretary, and these reports would be published in the *Rhode Island Medical Journal*. He invited any chairman of any committee to supplement his remarks at this time if he desired to do so.

Dr. Harry C. Messinger, Chairman of the Committee on Ethics and Deportment, briefly reviewed the background of the cases brought before his Committee, and he urged the members of the Association to keep very accurate records regarding the treatment of each patient at the time of treatment, and thereby guarantee additional protection in the event of threatened action for mal practice.

The Secretary reported that the Executive Committee recommended the election to active membership in the Association Dr. William Andrew McDonnell, and Dr. Francis William Nevitt. Dr. Henry Utter moved the unanimous election of these applicants to membership in the Association. The motion was seconded and adopted.

Dr. Cook announced that he was appointing a committee to consist of Dr. Charles McDonald and Dr. Samuel Clark to prepare the Association's tribute to the late Dr. Milton Korb.

Dr. Cook announced that the February meeting of the Association would be a joint meeting with the Rhode Island Medical Society, and he stated that it was hoped that Major General Paul R.

Hawley, Acting Surgeon General of the United States Veterans Administration, would be present, together with Dr. Herman C. Pitts, President-elect of the Society and Chairman of the Surgical Insurance Study Committee, to address the membership.

Dr. Cook invited Dr. B. Earl Clarke to return to the rostrum to present Dr. Benjamin Castleman, acting Pathologist, Massachusetts General Hospital. Dr. Castleman spoke on the subject, "Pulmonary Embolism and Infarction."

Dr. Castleman spoke of the discrepancies which in the past have been common between antemortem X-ray findings and postmortem observations. He told of a satisfactory technique for taking chest films of cadavers and mentioned a technique of inflating the lungs so as to make them more lifelike.

He stressed the fact that infarcts are not typically triangular in shape. They are of this shape at the costophrenic angle, but the apex of the triangle is at the margin, the base of the triangle being located proximally. This proximal, somewhat rounded aspect of an infarct is referred to as "Hampton's Hump," and may be seen roentgenologically.

Dr. Castleman stated that many white lines often considered healed tuberculosis or pseudo-septa are

continued on page 151

YEARS OF SERVICE

A New York physician writes us—

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this year.

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ESKADIAZINE

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ESKADIAZINE—the ideal oral sulfadiazine—
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**S.K.F.'s new, outstandingly palatable
fluid sulfadiazine for oral use**

PROVIDENCE MEDICAL ASSOCIATION
continued from page 149

in reality healed infarcts. Probably the source of emboli causing infarction is the deep veins of the legs in more than 95 per cent of cases. In combatting the situation, it is possible to tie even the inferior vena cava.

Dr. Castleman's clear and thorough exposition of his subject was very instructive. The meeting adjourned at 10:20 p. m. Attendance: 97. Collation was served.

Respectfully submitted,
FRANK W. DIMMITT, M.D., *Secretary*

KENT COUNTY MEDICAL SOCIETY

The January meeting of the Kent County Medical Society was held on January 10, 1946, at the Toll Gate in Westcott.

Minutes of the December meeting were read and accepted.

The Hospital Investigation Committee reported as follows:

Dr. George Young, Chairman, stated that this Committee met on December 26 and decided to invite twelve representative lay members of Kent County as advisors to the next meeting scheduled for January 23. More complete details will be forthcoming at that time.

Dr. Guy Wells, guest speaker, then presented excellent and very interesting color projections of films taken during his stay with the 5th Army as Colonel in Africa, French Morocco, Italy, Naples, Avelina, Sorrento, Cap Gris, Mount Vesuvius, Pompeii, Rome, etc. Dr. Wells emphasized the point that much illness prevailing among army personnel would have been avoided had the country, the terrain, and its climate been known and well understood beforehand.

Dr. Cogswell, also an Army Colonel, accompanying Dr. Wells, spoke of his recent experiences while in Japan, where now epidemics of tuberculosis, diphtheria, amebic dysentery, etc., are rife. He stressed the point that tropical medicine is no longer confined to the tropics but will be part of our medical practice now that our men are returning from these countries where malaria and filariasis were endemic.

The meeting adjourned. Dinner was served.

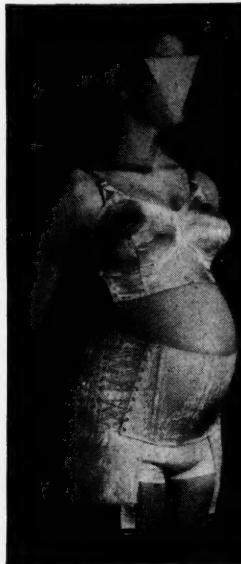
There were fifteen members present and two guests.

Respectfully submitted,
J. E. VIDAL, M.D., *Secretary*

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A Spencer antepartum support
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Vitamin B₂ (Riboflavin) 2 mg.

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Because of its rational composition, Darthonol merits inclusion in every anti-arthritic program. The combined pharmacodynamic and nutritional influence of its nine active ingredients makes it an efficacious therapeutic measure whenever the chronic arthritides must be combated.

*The Primer on Arthritis prepared by a Committee of The American Rheumatism Association and published in The Journal of The American Medical Association, volume 119, page 1089, August 1, 1942.

Complete bibliography on request

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ANNUAL REPORTS
of the
PROVIDENCE MEDICAL ASSOCIATION
1945

ANNUAL REPORT OF THE SECRETARY

Providence Medical Association, January 7, 1946

During the year 1945 the Providence Medical Association held eight regular meetings, two of which were joint meetings, one with the Rhode Island Medical Society in February, and one with the Rhode Island State Dental Society in November. Seven members of the Association and eleven out-of-state speakers contributed to the scientific programs at these meetings. The average attendance at the meetings was 90 members.

The topics and the speakers presenting them during the year were as follows:

"Management of Vaginal Bleeding," by Dr. Mario A. Castallo of Philadelphia.

"Practical Aspects of the Treatment of Shock," by Dr. Charles Janeway of Boston.

"Lessons Learned from the Treatment of Burns from the Hartford Circus Disaster," by Drs. Donald B. Wells, John C. Leonard, Ralph E. Kendall, and Maurice T. Root of Hartford.

"Coarctation of the Aorta," by Dr. Frank T. Fulton.

"Pancreatic Insufficiency and the Coeliac Syndrome," by Dr. Sidney Farber, of Boston.

"The Medical Aspects of Air Pollution," by Dr. Clarence A. Mills of Cincinnati.

"Hugh Owen Thomas: The Apostle of Rest," by Dr. Roland Hammond.

"The Uses of Purified Human Fibrinogen and Thrombin in Medicine and Surgery," by Dr. Orville T. Bailey of Boston.

"Doctor, Your X-Ray Burned My Patient," by Dr. Philip Batchelder.

"Global Medicine," by Dr. Charles F. Branch of Boston.

"Medical and Dental Relations," by Dr. Albert L. Midgley.

"Manifestations of Disease of the Mouth," by Dr. Paul E. Boyle of Philadelphia.

"Some Practical Aspects of the Sterility Problem," by Dr. George W. Waterman—Dr. Earl B. Clarke discussed histological changes involved in various structures. Dr. Laurence A. Martineau discussed the X-Ray aspects of the Problem.

With the provision that interns who had completed service in local hospitals prior to enlistment could be eligible for membership in the Association, the total enrollment reached the highest in the history, with 573 active and associate members listed as of December 31, 1945. Seventeen members were elected to active membership, one to associate membership, and one member was reinstated. Three members resigned because of transfer of residence out of the state, one member was granted a leave of absence for postgraduate study outside the state, and two members were dropped for non-payment of dues.

During the year eight members died:

Harry Broadman (January 5)

Carl Doten (April 23)

Henry A. Lange (May 22)

Anna Topaz (June 19)

William S. Streker (July 8)
 F. H. McCaffrey (July 21)
 William Hindle (July 26)
 Milton Korb (December 29)

With the cessation of hostilities on all the war fronts the Association has had the pleasure of welcoming back many of its members to civilian medical practice. As of December 31, approximately 41 members have resumed private practice. To publicize the return of these physicians and also to encourage their patients to return to them for medical care, the Association has initiated a series of paid advertisements in the *Providence Journal* under the direction of the War Veterans Committee of the Association.

During the year the Executive Committee has met regularly to conduct the business of the association and to carry on the many activities necessitated by the war effort as well as the reconversion to peacetime standards. The Committee recommended to the Association the formation of a War Veterans Committee through which the facilities of the Association and its membership could be placed at the disposal of returning physicians. The Committee also recommended the formation of a Committee on Smoke Abatement which has carried on a very successful public campaign to educate the people of Providence to the health hazards of smoke. The Association also in the course of the year adopted the resolution calling for state action to prevent the pollution of rivers of the state and of Narragansett Bay.

In October the Annual Golf Tournament and Dinner of the Association was revived, and it was considered one of the most successful affairs of its kind held at the Agawam Hunt Club with a large turn-out of members.

Through the generosity of former Presidents Emery M. Porter and Albert H. Jackvony, silk American and State Flags with standards now adorn the platform of the Medical Library Auditorium.

FRANK W. DIMMITT, M.D., *Secretary*

ANNUAL REPORT OF TREASURER — 1945

Providence Medical Association

RECEIPTS

Cash on Hand January 1, 1945	\$2,513.09
Checks not cashed December, 1944	178.59

Check returned	\$2,334.50
	15.09

Membership Dues	\$2,349.59
Dividends—U. S. War Savings Bonds	5,501.25

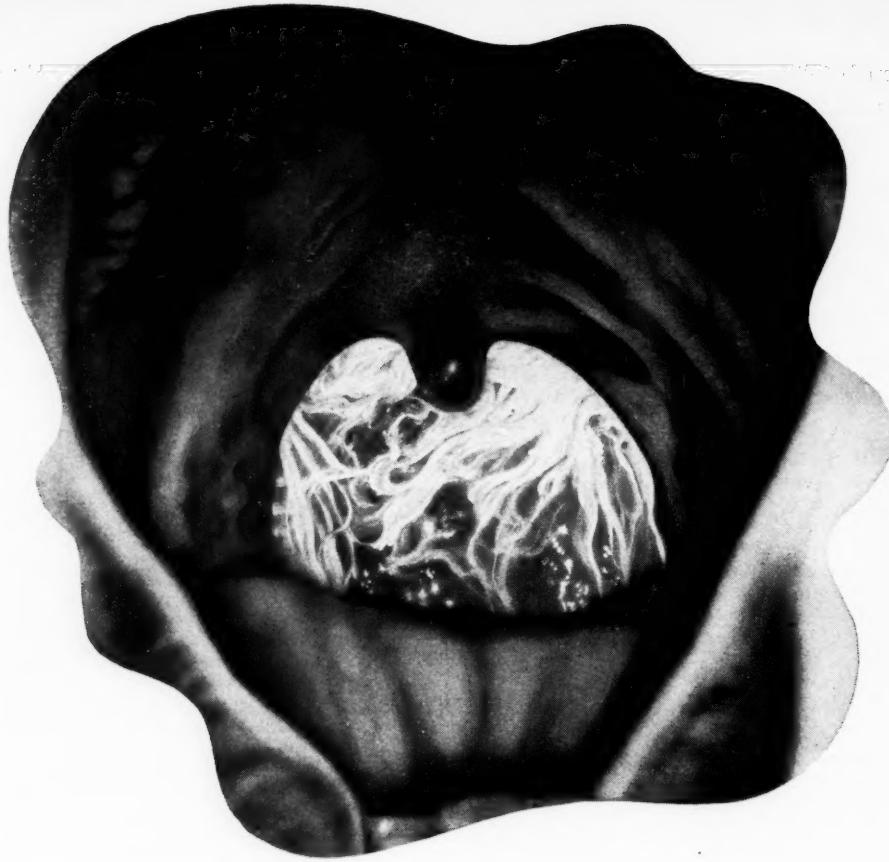
Checks not cashed December, 1945	42.18
	398.00

	\$8,291.02
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Investments

U. S. War Savings Bond, purchased Dec. 1943	\$ 740.00
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continued on page 159



Illustrated is the sulfathiazole-frosted pharynx of patient A.K., *two hours* after Paredrine-Sulfathiazole Suspension had been instilled intranasally.

WHY SUCH RAPID RELIEF

TO OBTAIN BEST RESULTS . . . the sore throat patient should not eat or drink fluids for one or two hours after instillation of Paredrine-Sulfathiazole Suspension. He should also make every effort to reduce nose-blowing and throat-clearing to a minimum.

Smith, Kline & French Laboratories, Philadelphia, Pa.

ANNUAL REPORTS

continued from page 155

U. S. War Savings Bond, purchased Feb. 1944	1,000.00
(Dividend Sept. 1944, March and Sept. 1945 \$36.41)	
U. S. War Savings Bond, purchased Dec. 1944	1,000.00
(Dividends March and Sept. 1945 \$19.68)	

EXPENDITURES

Collation after Scientific Meetings	\$ 440.00
Telephone Service	160.98
Donation to Rhode Island Medical Society for use of Building	540.00
Medical Journals and Binding	498.31
Salaries	2,183.96
General Expenses	1,572.48
Collector of Internal Revenue	284.49
Insurance	238.08
Defilescope	191.00
Partial payment, Executive Secretary's ex- penses at A. M. A. Meeting and Secre- taries' Conference	125.00
	\$6,234.30
Cash on Hand January 1, 1946	2,056.72
	\$8,291.02

HERBERT E. HARRIS, M.D., *Treasurer*

ENTERTAINMENT

The Committee on Entertainment of the Providence Medical Association herein submits its annual report.

We have arranged and provided for the collation following the regular monthly meetings of this association. We are particularly grateful to our executive secretary Mr. John E. Farrell for attending to the details of this function.

We are happy to announce that the institution of the annual golf tournament and dinner of the association has been resumed this year after several years' postponement during the war. This function was held at the Agawam Hunt Club on October 17, 1945. A record attendance of members and their guests was registered at the links as well as at the dinner. The President's Cup was awarded by Dr. Earl Clarke to Dr. Clifton Leech for low net score. Many prizes were awarded to members and guests, golfers and non-golfers alike. The performance of a professional entertainer was received with considerable enthusiasm and enjoyment. All comment received by your committee was most favorable.

The chairman wishes at this point to acknowledge with gratitude the cooperation of the individual members of the committee particularly Drs. Carl Sawyer and Ralph DiLeone for their untiring efforts and to Dr. Bolotow our perennial member ex-officio.

HERMAN P. GROSSMAN, M.D., *Chairman*
E. WADE BISHOP, M.D.
WILLIAM J. BUTLER, M.D.
RALPH DiLEONE, M.D.
CARL D. SAWYER, M.D.

ETHICS AND DEPORTMENT

While no threatened suits for malpractice were presented during the past year, yet the Committee was active in three matters involving matters of ethics and deportment,

each case arising from a different source. One investigation was the result of a complaint by a patient against a member who resorted to police force to eject the patient from his office. Another case involved a complaint by an insurance company against a member who had certified a patient as being unable to work who did work and collected compensation from the insurance company at the same time. The third case involved a member who was subject to public criticism in the daily press for action taken in an adoption case.

In each instance the Committee made complete investigations and reports.

As the result of the varied problems that come before the Committee in the course of its work it is apparent that each member should be careful to keep clear and accurate records on every patient, should possess liability insurance for himself, and should be prompt in reporting to the Committee any threatened malpractice suit, or any attack upon his medical ethics.

HARRY C. MESSINGER, M.D., *Chairman*
ANTHONY CORVESE, M.D.
RUSSELL R. HUNT, M.D.
LOUIS I. KRAMER, M.D.
ANDREW MAHONEY, M.D.
HENRY B. MOOR, M.D.
WILLIAM S. STREKER, M.D.
JOHN G. WALSH, M.D.

BUREAU FOR HANDICAPPED

There have been no meetings in 1945 of the entire committee appointed by the Association to advise the Bureau for Handicapped which is now known as the Community Workshops, Inc.

continued on page 161



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ANNUAL REPORTS

continued from page 159

The Chairman has completed for the workshop papers which required the signature of a physician, has advised the Executive Committee of the workshop on a number of matters, and has attended meetings of the same committee.

CLIFTON B. LEECH, M.D., *Chairman*
 KATHERINE CUTTS, M.D.
 RAYMOND F. HACKING, M.D.
 WILLIAM A. HORAN, M.D.
 LOUIS A. SAGE, M.D.
 FRANCIS B. SARGENT, M.D.
 CATHERINE ZOURABOFF, M.D.

NURSING

As in the past, the Committee on Nursing has had as one of its major functions that of serving in an advisory capacity to the Providence District Nursing Association. The counsel of the Committee has been mainly secured from the chairman, Dr. William Hindle, until his death in July. There has not been occasion for the Committee to meet formally, but on several occasions members have contributed information and advice to various problems concerned with nursing in the community when questions arose which were concerned with their special fields of medicine.

The Committee takes this opportunity to publicly express its appreciation of the service that Dr. William Hindle rendered to the various nursing organizations in Providence as the Chairman of this Committee for several years. His services have brought forth comments from many organizations.

WILLIAM A. HINDLE, M.D., *Chairman*
(Deceased July, 1945)
 PAUL C. COOK, M.D., *Acting Chairman*
 HARMON P. B. JORDAN, M.D.
 JAMES H. FAGAN, M.D.
 CHARLES BRADLEY, M.D.

PRE-SCHOOL EXAMINATIONS

As in previous years during the war the educational and organizational work of pre-school examination programs has been carried by the Providence School Department and the Parent-Teacher Association. Under the direction of Dr. Charles B. Lewis, director of health and physical education in the Department of Public Schools, and Mrs. E. Gardner Jacobs, Health Chairman of the Rhode Island Congress of Parents and Teachers, there has been no abatement in the efforts to expand this very important activity during 1945.

The general procedure has been somewhat as follows:

Early in February a letter and forms to be filled in with names of pupils who will enter school in September is sent to all elementary schools. These forms are filled in and are returned to the Health and Physical Education office before the end of that month. Then a letter is directed to each parent with the enclosure of pre-school forms which are returned to Mrs. Jacobs so that she may later organize members of the PTA to visit homes during April and May for follow ups to note whether the blank had been received, the examination made, what defects were found and if arrangements had been made for the correction of them. The school nurses also cooperate in the program in their visits to homes where there were children to enter school. During February and March effort is made to secure newspaper publicity to create public interest in the program.

The Committee of the Association serves mainly as an advisory group on the medical procedures involved in

the pre-school roundup. During 1945 it was not necessary to hold any meetings. The results of the 1945 campaign will be tabulated and will be made public sometime in the spring of 1946.

ROBERT M. LORD, M.D., *Chairman*
 MICHAEL J. NESTOR, M.D.
 HAROLD G. CALDER, M.D.
 CHARLES B. LEWIS, M.D.
 FRANCIS V. CORRIGAN, M.D.
 MERLE M. POTTER, M.D.

READING ROOM

As in the past the Reading Room Committee has supervised the purchase of publications by the Association for use by members at the Medical Library. These excellent periodicals, available for use at the Library or on loan to any member, constitute a valuable reference file on current medical literature. The Committee urges members to utilize these publications when visiting the Medical Library.

Journals purchased during 1945, and available for reference are:

American Heart Journal
 American Journal of Diseases of Children
 American Journal of the Medical Sciences
 American Journal of Obstetrics and Gynecology
 American Journal of Ophthalmology
 American Journal of Roentgenology
 American Journal of Syphilis, Gonorrhea and Venereal Diseases
 American Review of Tuberculosis
 Annals of Surgery
 Archives of Dermatology and Syphilology
 Archives of Neurology and Psychiatry
 Archives of Ophthalmology
 Archives of Otolaryngology
 Archives of Surgery
 Brain
 British Journal of Surgery
 British Medical Journal
 Bulletin of Johns Hopkins Hospital
 Endocrinology
 Gastroenterology
 Journal of Bone and Joint Surgery
 Journal of Experimental Medicine
 Journal of Laboratory and Clinical Medicine
 Journal of Nervous and Mental Disease
 Journal of Pediatrics
 Journal of Thoracic Surgery
 Journal of Urology
 Lancet
 Medical Record
 Medicine
 Military Surgeon
 Modern Hospital
 Public Health Economics
 Quarterly Cumulative Index Medicus
 Radiology
 Surgery
 War Medicine

EDWARD S. CAMERON, M.D., *Chairman*
 LOUIS GOODMAN, M.D.
 FRANCESCO RONCHESE, M.D.

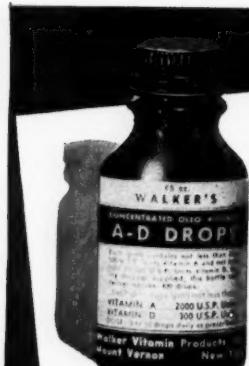
TUBERCULOSIS

The Committee on Tuberculosis has had one meeting during the past year. The matters that came up for discussion were:

1. Whether or not personnel turned down or discharged by the armed services because of tuberculosis were reported to proper local health authorities.

continued on page 172

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H. P. Hood Co.	DE 3024
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**REPORT OF THE MILK COMMISSION OF THE
PROVIDENCE MEDICAL ASSOCIATION**

1945

CERTIFIED MILK in Providence during 1945 was obtained from the following farms: Cherry Hill Farm, North Beverly, Mass.; Fairoaks Farm, Lincoln, R. I.; Hampshire Hills Farm, Wilton, N. H.; Walker-Gordon Farm, Charles River, Mass.

Through the courtesy and co-operation of the Boston Commission we have accepted their certification of two farms from Massachusetts and one from New Hampshire.

Bacteriological and chemical examinations of certified milk are made in the laboratories of Brown University under the supervision of Professor Charles Stuart. The potency test on the Vitamin-D milk was carried on in the laboratory of Dr. L. R. Parkinson of Massachusetts State College, Amherst, Massachusetts, and all three milks were found to contain 400 units per quart. These Certified milks are now modified by the addition of a vitamin-D concentrate.

All of the herds are under State and Federal supervision and are free from Tuberculosis and *Brucella abortus* infections.

Much credit is due the management of these farms in keeping the standards of Certified milk on a high plane and these high ideals have been realized in spite of the acute shortages in materials and labor.

During the late summer one of the farms experienced some difficulty in keeping their bacteriological counts within normal limits, but after an intensive study by Professor Stuart's workers, it was found that by renewing the teat cups, which were made of synthetic rubber, the trouble cleared up rather quickly.

Now that more essential materials are becoming available on the farms it is hoped that all the farms can even better their excellent records.

During the past year the Commission has carried full page advertisements in the R. I. MEDICAL JOURNAL in an attempt to keep the "Quality Milk" before the medical profession.

The Commission is indebted to Dr. Edwin Knights, Deputy Inspector of Milk in Providence, for his continued interest and advice during the past year.

*HAROLD G. CALDER, Chairman
REUBEN C. BATES, Secretary
THOMAS J. DOLAN
JOHN LANGDON
FRANK I. MATTEO
WILLIAM P. SHIELDS
HENRY E. UTTER
GEORGE W. WATERMAN
RAYMOND L. WEBSTER, D.M.D.*

MONTHLY AVERAGES OF CERTIFIED MILK FOR 1945

	CHERRY HILL H. P. HOOD			FAIROAKS			HAMPSHIRE HILLS			WALKER- GORDON			
	Pasteurized		Bac- teria per C.C.	Pasteurized		Bac- teria per C.C.	Pasteurized		Bac- teria per C.C.	Vit. D. Pasteurized		Bac- teria per C.C.	
	B.F.	T.S.		B.F.	T.S.		B.F.	T.S.		B.F.	T.S.		
January.....	3.8	12.31	17	4.6	13.60	6,950	31	4.0	12.81	17	4.0	12.93	24
February.....	3.8	12.43	9	4.2	13.23	4,025	66	4.1	12.95	33	4.1	12.90	11
March.....	3.7	12.25	37	4.1	13.04	4,994	250	4.0	12.83	49	3.9	12.82	10
April.....	3.7	12.44	10	4.1	12.84	5,000	119	3.8	12.49	54	3.8	12.63	16
May.....	3.8	12.16	28	4.0	12.78	3,545	337	3.9	12.66	83	3.8	12.51	16
June.....	3.8	12.38	44	3.5	12.22	6,878	171	4.0	12.78	465	3.7	12.29	18
July.....	3.8	12.30	53	3.9	12.60	13,566	46	4.0	12.71	144	3.7	12.49	17
August.....	3.7	12.33	54	5.0	12.78	6,327	171	3.9	12.47	268	3.8	12.52	17
September.....	3.7	12.35	71	4.0	12.73	4,175	231	3.9	12.68	50	3.8	12.56	19
October.....	3.9	12.50	42	4.2	13.41	2,487	84	4.0	12.59	57	3.9	12.67	32
November.....	3.8	12.46	15	4.3	13.27	2,294	35	4.0	12.71	99	3.9	12.73	29
December.....	4.1	12.77	21	4.7	13.94	2,991	67	4.1	12.90	97	3.9	12.67	29
Yearly Average.....	3.8	12.39	33	4.2	13.04	5,269	134	4.0	12.71	118	3.8	12.64	20



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THE WASHINGTON SCENE: The Hill-Burton hospital construction bill passed the Senate on December 12 with no outright opposition expressed at any time through its discussion on the floor. Senator Murray offered seven amendments but the only one accepted was that which provides a few more health centers than provided for in the bill. Referred in the House to the Interstate and Foreign Commerce Committee the act will be subject to hearings there this month * * * * * The Maternal and Child Welfare act, better known as the Pepper bill, will have plenty of support from women's clubs, P.T.A., and similar groups as the result of propaganda sent out by the Children's Bureau whose administering group of eleven women and two men, only three of whom are doctors, evidently see in it a continuance of the EMIC program under which a million wives and infants of servicemen have been cared for * * * * * In the 1944-45 period the EMIC expenditure in Rhode Island was better than \$238,000 * * * * *

VETERANS: The passage of the bill providing for a new department of medicine and surgery in the Veterans Administration kicked up quite a controversy due to the provisions for appointment and discharge of doctors without Civil Service approval * * * * * The new hospital for veterans to be erected in Davis Park is slated to be a 418-bed general hospital for general medicine and surgery for which an appropriation of \$3,404,222 has been provided * * * * * Many of New York City's doctors who gave up their practices to go to war were reported in the press to be enraged by rent gougers demanding exorbitant rentals for what few vacancies as existed * * * * * The study of the incidence of nervous conditions among World War II veterans recently carried on in Rhode Island with the cooperation of the medical society marks the first such survey in the country * * * * * We are still puzzling over a Veterans Administration ruling noted in our readings which read: "Part 25, (25.6060) 'At prescribed rates' the Veterans Administration may provide outpatient medical

and dental treatment to employees of the Veterans Administration and to the families of such employees; also to the general public in emergencies. Published September 21."

MEETINGS: The American College of Physicians will resume its annual meetings with this year's session slated for Philadelphia from May 13-17, inclusive. Headquarters there will be at the Municipal Auditorium * * * * * When the AMA meets at San Francisco next July it will undoubtedly include a Section on General Practice since a resolution providing for such a grouping was adopted by the House of Delegates at the Chicago meeting in December * * * * * Dr. Roger I. Lee came up with a fine suggestion in his acceptance address upon his elevation to the Presidency of the AMA when he recommended that there be an additional mid-winter meeting of the House of Delegates of the AMA to permit a more careful study of organized medicine's problems * * * * *

PUBLIC HEALTH: Appointments to fill vacancies in the Reserve Corps of the USPHS are now being made, and examinations for Regular Corps appointments will be held in April and May * * * * * Physicians are needed immediately for duty in hospitals, in the tuberculosis and venereal disease control programs, and in other activities of the Service * * * * * Twenty-eight hospitals, totalling more than 26,000 beds, have been purchased by the UNRRA from Army surpluses in the United Kingdom and on the European continent and have been shipped to Poland, Czechoslovakia and Yugoslavia * * * * * Risk of introduction of an epidemic of malaria by returning soldiers from overseas is continually decreasing according to the Army Medical Corps staff leaders * * * * * Meanwhile the most important epidemic disease in Japan, according to reports by Japanese civilian officials to the Pacific office of the chief surgeon, U. S. Army, has been diphtheria * * * * * Tokyo City reported more than three thousand cases during the first eight months of 1945 * * * * *

continued on next page

THROUGH THE MICROSCOPE
concluded from preceding page

PRIZES: The American Physicians Art Association, with the cooperation of Mead Johnson & Company, is offering an important series of Savings Bonds as prizes to physicians for the best artistic works depicting the medical profession's "skill and courage and devotion beyond the call of duty" * * * * * An annual prize contest will be conducted again this year by the American Association of Obstetricians, Gynecologists and Abdominal Surgeons * * * * * A cash prize—not to exceed 500—is offered by the American Urological Association for an essay on the result of some specific clinical or laboratory research in urology * * * * *

WAR DOCTORS: By the first of the year the discharges of Army doctors were reported by the Office of the Surgeon General to be running far ahead of the schedule announced last September * * * * * It may be so, but we know of a good many of our doctors, some in far away spots, who would like the discharge schedule to catch up with them before they forget all knowledge of civilian medical practice * * * * * The 48th Evacuation Unit, which was composed chiefly of doctors and nurses from Rhode Island, won the meritorious unit plaque for services rendered to the Chinese Army in India from April to September, 1944 * * * * * Fourteen Army General Hospitals, including the one at Camp Edwards, will be closed March 31 according to present Army Medical Department plans * * * * * In World War I, 3,954 Army doctors, nurses and enlisted men of the Medical Department were killed or wounded. As of August 1, 1945, the Medical Department battle casualties were listed at 24,401 for World War II, with some 4,436 doctors, dentists, veterinarians, nurses and enlisted men killed, or dead of wounds, and another 605 listed as missing in action * * * * *

EDUCATION: Each new applicant for membership in the Los Angeles (Cal.) County Medical

RHODE ISLAND MEDICAL JOURNAL

Society will henceforth be required to attend a course of lectures by qualified instructors, designed to augment his knowledge of California laws affecting the practice of medicine, of malpractice prophylaxis, of professional ethics and courtesy, and the Association's history, accomplishments and aims, and of other essential subjects * * * * * Meanwhile from Nashville, Tenn., we continue to receive brochures from a Dr. Cheatham extolling the opportunities of the Nashville College of Naturopathy * * * * *

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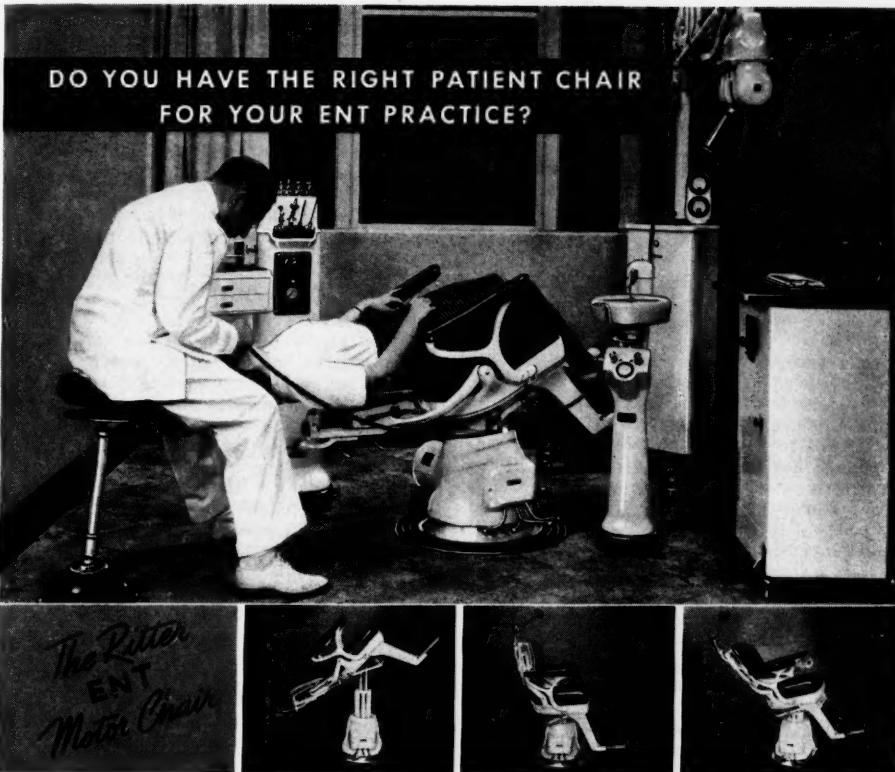
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PROVIDENCE

ANNUAL REPORTS

continued from page 161

2. Whether the cases of tuberculosis discovered on routine x-raying at Walsh-Kaiser were being followed.
3. Whether or not the present system of reporting tuberculosis in civilian practice was adequate.
4. Progress in industrial pre-employment examinations.

It was felt that the local induction authorities had been very cooperative in reporting their cases of tuberculosis, but that since the transfer of the induction center to Boston the reports had not come through so well and that for the men that had been discharged from service chief reliance for reports rested with the civilian physicians whom the discharged veterans consulted.

The cases found at Walsh-Kaiser have apparently all been reported and followed either by local physicians or by one of the tuberculosis clinics of the city or state.

In regard to the reporting of tuberculosis by civilian physicians, it was felt that frequently the physicians were remiss, and that some system to stimulate the reporting would be advisable.

It was the consensus of opinion that the blanks for reporting should be simplified and that one blank should be used for all reportable diseases. It was further suggested that some penalty might be imposed by proper authority on those who failed to comply with the regulations or some compensation provided for those complying.

In regard to pre-employment and routine x-raying in industry, Dr. Pinkney reported that the demand for the use of the mobile unit is becoming more general and that certain labor organizations are taking a more favorable attitude toward it than formerly.

JOHN C. HAM, M.D., *Chairman*
 ROYAL C. HUDSON, M.D.
 DANIEL A. SMITH, M.D.
 PHILIP BATCHELDER, M.D.
 KATHLEEN M. BARR, M.D.
 CHARLES L. SOUTHEY, M.D.
 PETER F. HARRINGTON, M.D.
 UBALDO E. ZAMBARANO, M.D.
 JAMES P. DEERY, M.D.

WAR VETERANS

Late in the Spring the President of the Association, by action of the Executive Committee, appointed a War Veterans Committee to assist the members of the Association returning to the district to resume private medical practice. The Committee consists of officers of the Association, as well as members, particularly suited to represent hospital, industrial health and veterans problems.

The chairman of the Committee, together with the executive secretary of the Association, attended a meeting with representatives of the U. S. Department of Commerce con-

RHODE ISLAND MEDICAL JOURNAL

cerned with the disposal of surplus property. Information of interest to physician-veterans acquired as the result of this conference was passed along to each member of the Association in the armed forces. The chairman of the committee has endeavored to interview as many returning physicians as possible to offer each the full services of the Association.

In September the House of Delegates of the Rhode Island Medical Society acted favorably on the proposal stemming from this Association that a Veterans Service Bureau be established in connection with the executive office. As the result of this action the work of our committee has been closely allied with that of the new program whereby information of vital interest and value to doctor-veterans is disseminated through the executive offices. The success of this plan is best attested by the many communications received from members in the Services praising the efforts by the district and state organizations in their behalf, as well as the inquiries from other district and state medical societies that have learned of the work here.

To publicize the return to private practice of members the Association is purchasing space in the *Providence Journal* once each month wherein to list the name, office address, and office telephone of physicians resuming civilian work. The first such display appeared on Thanksgiving Day, the second on Christmas Day, and others will follow in Sunday issues of the paper during the coming months.

There are many problems facing the physician resuming private practice, ranging from the securing of malpractice insurance to the purchase of an automobile. Undoubtedly the most serious problem, however, is that of acquiring office space, and in many instances a family residence. The Veterans Bureau of the State Society, aided by our Committee, appealed to the realtors of the State and also secured a front page news story to publicize the problem. These actions resulted in the compiling of a file of possible sites for physicians' offices which was mimeographed and distributed to every war-doctor.

The Committee urges the members of the Association to continue their splendid efforts in behalf of the returning veterans, and it hopes that every member will continue to be cognizant of the increasing difficulties that will face the men yet to return—difficulties that will certainly call for the complete support of the Association for solution.

ALBERT H. JACKVONY, M.D., *Chairman*
 PAUL C. COOK, M.D.
 FRANK W. DIMMITT, M.D.
 HENRY S. JOYCE, M.D.
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